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THE TREATMENT OF TETANUS*

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During the interval between March 22, 1916, and Dec. 7, 1921, forty-nine patients with tetanus were admitted to the Los Angeles County Hospital. During this interval there were 74,393 total admissions, or one admission for tetanus to 1,518 admissions for all other causes. Twenty-six deaths occurred, or a mortality of 53 per cent. An analysis has been made of the records of these forty-nine patients in the hope that certain deductions may be made as to existing methods of treatment.

PROPHYLAXIS

The prophylaxis of the disease has been so well established that but little discussion is necessary to convince one of its value. Probably, however, considering the population as a whole, not more than 1 per cent. of those who receive puncture wounds of the type considered most liable to tetanus infection receive such treatment by physicians, for the reason that they are not consulted. A large majority of people believe their own simple methods of wound treatment efficient and sufficient. On the other hand, physicians are sometimes guilty of neglect, although few of the patients whose records have been studied in this series were seen by physicians prior to the onset of the disease. As a result, there was no record of prophylactic injection in any case, despite the fact that, in a few instances seen by physicians, the character of the injury should have aroused suspicion of the possible consequences.

I am indebted to the Surgeon General of the United States Army for data dealing with the prophylaxis of wounds received in action among our soldiers during the World War. The instructions called for the injection of antitetanic serum as soon as possible after all war wounds. The usual dose was 1,500 units. This was repeated within ten days. The instructions also called for a repetition of the dose, for patients on whom subsequent operation was done, care being taken to prevent an anaphylactic reaction. That these measures were effective is shown by the results obtained for, among 224,089 war wounds, only thirty-six patients developed tetanus, or one to each 6,224 wounds. This is in marked contrast to the disease incidence during the Civil War, before the introduction of antitetanic serum. Sanford [1] has stated that 505 patients developed tetanus among 246,172 wounded during the Civil War, or one to each 487 wounds. Bazy [2] observed 200 wounded from the same sector during the World War. One hundred received tetanus antitoxin, and only one developed tetanus (the day after injection), while among 100 who, for one reason or another, did not receive antitoxin, eighteen developed tetanus.

The British war statistics, as given by Sir David Bruce,[3] are convincing. He has shown that among 2,032,142 wounded, tetanus developed in 2,385, or an incidence of 1.17 per thousand. He [4] has emphasized the fact that before the routine use of antitoxin the incidence of tetanus among the wounded was from 15 to 32 per thousand, while after its routine use the incidence never rose above 2 or 3 per thousand.

THE PROPHYLACTIC DOSE

The British in the earlier days of the World War used 500 units of antitoxin as the prophylactic dose. In June, 1917, it was ordered that four such inoculations should be given at intervals of seven days. In August, 1918, this order was changed, and one dose of 1,500 units was given. The War Office Committee for the study of tetanus has stated it was not conclusive that the larger dose more adequately protected, the smaller dose having appeared to be as efficacious. In the United States the prevailing custom has been to administer a prophylactic dose of 1,500 units, which is about the quantity sufficient to protect against 2,000 times the minimal fatal dose of toxin for a person weighing 150 pounds (68 kg.). Practically all of the antitoxic effect is eliminated in eight or ten days after the injection. Since this interval is about the usual incubation period, if a lacerated wound contains dead spaces, a foreign body or necrotic tissue, it will be wise to repeat the dose every eight or ten days, since in such instances tetanus may not develop for a number of weeks after the injury. The British statistics show that more than two million prophylactic injections of tetanus antitoxin were given during the war and that only eleven instances of anaphylactic shock occurred, in all of which the patients recovered. Tulloch [5] believes that the presence of pyogenic organisms in wounds is a predisposing factor of great importance, since symbiosis of bacilli or spores is necessary before tetanus toxin can be produced. This has not appeared to be true in a number of the patients in the series here reported, for clean healed wounds of a few days' duration have been followed by tetanus.

The prophylactic injection, in addition to its importance in lowering the disease incidence, deserves con-

* Read before the Section on Practice of Medicine at the Seventy-Third Annual Session of the American Medical Association, St. Louis, May, 1922.

1. Sanford: Bull. Internat. A. M. Museum **7**: 365, 1918.
2. Bazy: Bull. et mém. Soc. de chir. de Paris **42**: 2919, 1916.
3. Bruce, D.: J. Hyg. **20**: 1 (July) 1920.
4. Bruce: Brit. M. J. **1**: 118 (Jan. 27) 1917.
5. Tulloch, W. J.: Proc. Roy. Soc. London **40**: 529, 1917-1919; Brit. M. J. **1**: 164 (June 1) 1918.

sideration for its influence on the incubation period, which in turn affects the mortality. The British statistics show that among those patients who received a prophylactic dose of 500 units, and who subsequently developed tetanus, the average incubation period was 45.5 days; while among those who did not receive the prophylactic dose, the average incubation period was 10.9 days. The prophylactic dose lowered the mortality, which was 53.3 per cent. among those who had not had it, to 22.5 per cent. among those who developed tetanus after receiving it. It should be the rule to give a prophylactic dose of antitoxin whenever a wound, even though healed, is to be reopened. This refers particularly to operations on compound fractures and exploration for foreign bodies, or for the removal of dense cicatrices.

THE TYPE OF WOUND AND ITS PRIMARY SURGICAL TREATMENT

The anaerobic conditions favorable to the growth of tetanus bacilli are augmented in contused lacerated wounds in which destruction of tissue and blood supply has occurred. A considerable proportion of wounds capable of carrying tetanus infection are not of such an extensive character. Tetanus bacilli occur normally in the intestinal tracts of many horses, cattle and other animals, such as dogs and cats, which take up with their food a considerable quantity of soil dirt. It has been stated by Ashhurst [6] that tetanus bacilli are found in 5 per cent. of human intestinal tracts. Two of the patients in the present series developed tetanus from infected bedsores which presumably came in contact with dejecta, while another instance followed operation for gangrenous appendicitis. The catgut used was not entirely excluded as a source of infection in this patient, although the statement was made at the hospital where the operation was performed that "the suture material was boiled for twenty minutes." Tetanus also occurred in another patient of this series nine weeks after an operation for hernia. No other point of entrance of the infection could be found. In Table 1 will be found a description of the types of injury responsible for the infection in forty-nine cases.

TABLE 1.—TYPES OF INJURY RESPONSIBLE FOR TETANUS IN FORTY-NINE CASES

Injury	Number of Cases
Punctured nail wound of foot	9
Contusion of finger	8
Lacerated wound of foot	6
Sliver in foot	3
Bedsore on buttocks	2
Sliver in buttock	1
Sliver in hand	1
Sliver in leg	1
Lacerated wound of leg	1
Stubbed toe injury	1
Abrasion of heel from new shoe	1
Infected wound abdomen following gangrenous appendicitis	1
Hernia operation, wound clean	1
Curettage for incomplete abortion	1
Laceration of perineum and multiple fractures	1
Compound fracture of tibia and fibula	1
Abrasion of back due to rock missile	1
Scratch on hand	1
Rabbit bite of wrist	1
Infected sore of scalp	1
Multiple lacerations following automobile accident	1
Infected umbilicus (infant 11 days old)	1
Unknown	3
Total	49

The largest number of cases, 46.6 per cent., followed injury of the feet and legs, while 24.3 per cent. followed injury of the upper extremity.

For simple injuries, the application of 3 per cent. iodin in alcohol with protection of the wound by a sterile bandage will ordinarily suffice. If, however, tissue laceration has occurred, primary excision and primary, or delayed primary, suture should be done. Sir David Bruce has stated that this method of wound treatment during the war took surgeons a long time to learn, but would probably have led to extinction of tetanus if the war had lasted longer. He has shown that, for war wounds, certain types of which certainly do not differ essentially from lacerated wounds seen in civil life, before primary incision and excision was practiced the incidence of tetanus was 103 per hundred thousand; by February, 1918, the incidence had dropped to 24; by May, 1918, to 12, and by June, 1918, to 8 per hundred thousand. The cautery should not be used, since it produces necrotic tissue, a condition favorable to the growth of the tetanus bacillus or spores. Three of our cases resulted from retained slivers or splinters of wood. Ordinarily these injuries receive but scant attention, although their importance as foreign body wounds favorable for the development of the infection deserve more consideration. Lacy and Murdock [7] have recently reported an instance of infection following a large, open, scrotal wound from which the testicle was removed for tuberculous orchitis and epididymitis. The wound was probably contaminated by anal discharges, since *B. coli* and *B. welchii* were present. Tetanus bacilli were isolated from the spinal fluid of this patient, which brings up the point that spores or bacilli may be engulfed by phagocytes and transported to distant parts of the body, there to originate other foci for the development of toxin.

TABLE 2.—INCUBATION PERIOD

Incubation Period	No. of Cases	Incubation Period	No. of Cases
3 days	1	10 days	4
4 days	4	11 days	6
5 days	1	12 days	1
6 days	2	14 days	6
7 days	2	From 20 to 23 days	3
8 days	1	27 days	1
9 days	4	63 days	1

The report of the committee for the study of tetanus of the British war office, cited by Bruce, showed that "it appeared safer to abstain from surgical interference with a wound after tetanus had appeared." It does not appear from their figures that interference was as dangerous as believed, since in such cases the mortality (24.3 per cent.) was apparently not increased.

THE INCUBATION PERIOD AND ITS RELATION TO MORTALITY

Among thirty-seven patients of this series, for whom the incubation period could be traced with reasonable accuracy, the shortest period was three days, while the longest period was sixty-three days. As will be seen in Table 2, the largest number of patients developed the disease in from ten to fourteen days after their injury.

Excluding the one patient with the sixty-three day incubation period, the average interval between injury and the onset of the disease for thirty-six patients was 10.8 days. The British statistics during the World War showed that the greatest number developed the disease on the tenth day after the wound.

6. Ashhurst, A. P. C.: Report on Tetanus, Arch. Surg. 1: 407 (Nov.) 1920.

7. Lacy, G. R., and Murdock, C.: J. Lab. & Clin. Med. 7: 100 (Nov.) 1921.

It has long been recognized that the shorter the incubation period the higher was the mortality. Of eight patients in this series who developed the disease up to and including the sixth day after injury, six died, giving a mortality rate of 75 per cent. Among twenty-four patients whose incubation period was from seven to and including fourteen days, twelve died and twelve recovered, a mortality rate of 50 per cent.; while among five patients whose incubation period was twenty days or longer three recovered and two died, a mortality rate of 40 per cent. The British statistics show that among 128 patients whose incubation period was seven days or under, the mortality was 58.6 per cent., while among 429 patients whose incubation period was thirty-five days or longer the mortality was 15.4 per cent. The statistics also show that among 400 wounds of the upper extremity which were followed by tetanus, the mortality was 39.5 per cent., while among 480 wounds of the lower extremity the mortality from tetanus was 36.1 per cent.

THE MORTALITY FROM TETANUS

The death rate before the introduction of tetanus antitoxin was about 85 per cent. The British war statistics have shown that among 1,437 patients treated in England, 501, or 34.8 per cent., died. These patients had comparatively long incubation periods, owing to the earlier prophylactic injection. Those who did not receive the prophylactic injection or whose incubation was shorter (averaging from twelve to thirteen days) were treated in the hospitals in France. Among 715 such patients, 510 died, a mortality rate of 71.2 per cent. The British total figures show that 2,152 soldiers developed tetanus during the World War, with 1,011 deaths, or 47 per cent.

Many factors enter into a study of the mortality rates reported from different hospitals. For example, Gessner,[8] who studied 368 case reports from the New Orleans Charity Hospital for the period 1906-1918, has expressed the pessimistic opinion that since the mortality was 70.7 per cent. "we must admit that we have progressed but little in the treatment of the disease." Such a conclusion seems hardly justified, for it may be pointed out that a high mortality of 71 per cent. among 121 patients who did not receive more than 10,000 units of antitoxin would not be unusual, in view of the method and size of the dose administered. His own figures show that among twenty-three patients who received more than 10,000 units of antitoxin the mortality was 56.5 per cent. It should be recalled that, in any series of instances of this disease (the acute cases of short incubation), the patients may die before there is time to administer antitoxin in sufficiently large doses to save life. In other words, the longer such patients live, the greater the probability that they will receive large and more adequate dosage. Again, it should be recalled that the virulence of the infecting strain may vary with different years. For example, among seven patients of our series, admitted in 1916, the mortality was 71 per cent., while among seven patients admitted during 1917 the mortality was 14.3 per cent. Again, among nine patients treated during the year 1920, the mortality was 44.4 per cent., while among ten patients treated during 1921 the mortality was 70 per cent.

The interval elapsing between the onset of symptoms and the time treatment is begun will likewise greatly influence mortality. It has been stated by Ashhurst that the amount of antitoxin required to prevent death increases in geometric progression with the lapse of time. If sufficient time has elapsed to allow toxin fixation in the nerve cells of the cord, the mortality will be greatly increased. The small amount of toxin necessary to kill, together with the time factor and inadequate antitoxin dosage, accounts for the high mortality of the disease. Twelve of the patients in the present series were not admitted to the hospital for treatment until after a lapse of three days or longer following the onset of symptoms.

SYMPTOMS

Trismus may be considered the most important early symptom. Neck stiffness and general muscular rigidity of the trunk muscles were also common. The deep, and in many patients the superficial reflexes were increased. In some patients, stiffness of the legs was mentioned as a symptom of early onset. In children, general convulsions occurred early in the disease. Pain was common as a result of movement affecting the rigid lumbar muscles or the diaphragmatic or intercostal movements in breathing. Opisthotonos was common.

The facial expression of those patients whose jaws were fixed was typical of the sardonic grin. Consciousness was generally not disturbed. Fever was not present as a rule early in the disease, but the pulse and respiration rates were increased. Localized clonic contractions of the muscles of the extremities also occurred as a frequent symptom. The pupils, as a rule, were equal, and reacted to light. Kernig's sign could not be estimated because of the general lumbar rigidity. Ankle clonus and a positive Babinski reflex may be present. The leukocytes were moderately increased, the average count approximately from 12,000 to 15,000, with a moderate polynucleosis (from 70 to 78 per cent.). The highest leukocyte count encountered on entrance was 17,600. The highest polymorphonuclear increase encountered was 93 per cent. The spinal fluid was usually under increased pressure, with a normal cell count and negative globulin test. After the injection of antitoxin intraspinally, the cell count was greatly increased and globulin was present, owing to the meningeal irritation produced by the serum.

Trismus as an initial symptom deserves special consideration from a prognostic point of view, since by it the physician may gage relatively the amount of toxin absorbed by the cells of the central nervous system. It has been observed repeatedly that among patients in whom the trismus progressed rapidly after the onset and was complete within twenty-four hours, the mortality was high, approximately from 60 to 70 per cent.; whereas among those who developed tardy and incomplete trismus the mortality was lower, probably not more than 30 per cent.

So-called chronic tetanus is not uncommon. In this form, trismus may be absent, but the muscles about a wound may show tonic or clonic contractions. The pulse rate will be increased, but, in the absence of secondary infection, fever may not be present. Such evidences may not occur for several weeks or months after an operation or injury, and seem to be more common when associated with low grade bone infections.

8. Gessner, H. B.: The Therapeutics of Tetanus, J. A. M. A. 71: 867 (Sept. 14) 1918.

TREATMENT

The toxin produced by the tetanus bacillus is one of the most powerful of known poisons. It has been estimated that $\frac{1}{300}$ grain of the dried toxin will be fatal for man. It is about twenty times more poisonous than dried cobra venom. The toxin reaches the central nervous system by way of the axis cylinders of the peripheral nerves, either by means of centripetal protoplasmic currents or by way of the lymph channels of the epineuria or perineuria. Robertson [9] believes that the lymph channels are important as a means of transportation of the toxin which gains access to the spinal cord through the motor roots, from which it spreads to the sensory side. Richardson has obtained tetanus bacilli in pure culture from lymph glands adjacent to the focus of infection. As a rule, it has not proved profitable to search for tetanus bacilli in wound secretions or adjacent glands. A better plan is animal inoculation of suspected material from wounds, or anaerobic culture by the Buchner or Wright method. The toxin present in the blood stream is probably small in amount and is not responsible for the symptoms, which occur only when access has been obtained to the cells of the central nervous system. Unfortunately, the nerve cells apparently have greater affinity for tetanus toxin than for antitoxin, a serious handicap in the treatment of the disease.

TABLE 3.—MORTALITY ACCORDING TO TOTAL DOSAGE

Total Dosage in Thousand Units	Number of Patients	Mortality, Per Cent.
From 10 to 15.....	7	42.8
From 15 to 25.....	8	62.5
From 25 to 40.....	8	75.0
From 40 to 60.....	11	54.5
From 60 to 100.....	7	42.8
From 100 to 200.....	3	33.3
From 250 to 350.....	4	25.0

The plan of treatment usually followed in this country has been based on the experimental work of Park and Nicoll,[10] who advocated early administration of from 3,000 to 5,000 units intraspinally, repeated in twenty-four hours, and from 10,000 to 15,000 units intravenously. Three or four days later, in order to continue the antitoxin effect for four or five days longer, a subcutaneous injection of from 10,000 to 15,000 units was advised. These authors have expressed the opinion that no advantage was gained in giving larger doses. Nicoll,[11] in reporting twenty cases of tetanus with a mortality of only 20 per cent., stated that 40,000 units was the usual total dosage given. Emphasis should be placed on the benefit following intraspinal treatment. Sherrington's experiments have likewise shown that, in animals, the lowest mortality followed subdural and bulbar injections.

We have believed that some patients of the series here reported were saved by much larger doses of antitoxin than those advocated by Park and Nicoll. In Table 3 will be seen the mortality according to the total dosage used. Forty-four of the forty-nine patients received intraspinal and intravenous injections as well as injections into the tissues about the wound, when such was present.

In the interpretation of these figures it should be borne in mind that the incubation period or the elapsed time before treatment was begun was not considered. It should be emphasized also that the tendency to give continued large dosage was more evident the longer the patient lived. This has been modified by more experience since it has been realized that there was probably little advantage in continuing large daily doses after the third or fourth day of treatment. Improvement, in fact, may not be evident until six or seven days after treatment has been begun. Failure to appreciate this fact has led many physicians to adopt other methods, such as the injection of phenol (carbolic acid) or magnesium sulphate, and when the patient has recovered, to ascribe the cure to the latter drugs. Experience has shown that such methods are of little value in the treatment of the disease. It has been interesting to note in the British war statistics given by Bruce that, of 214 patients who received 100,000 antitoxin units (fifty-six received more than 200,000 units), the mortality was but 11.4 per cent. Here, again, it should be recalled that many of the very acutely ill patients died before they received large doses.

From a survey of the literature, an analysis of the records of the patients of this series and personal experience, it is believed that the following plan of treatment as carried out in the hospital offers the best chance of recovery to patients with this disease:

1. Fluids should be given by mouth or rectum in sufficient amount to prevent dehydration. The amounts given and the quantities of urine passed should be recorded. If edema of the lungs occurs, the amount of fluid intake should be restricted to 500 c.c. daily. The urine should be examined daily.

2. Since metabolism is greatly increased because of the muscular spasms, it is necessary to secure quiet and relaxation in order to prevent exhaustion. For this purpose, phenobarbital (luminal) in 3 to 5 grain doses may be given by mouth or rectum if necessary every three to six hours. Chlorbutanol, from 15 to 30 grains in diluted alcohol or whisky, may also be used every three to six hours. Morphin, ¼ grain, with atropin, $\frac{1}{100}$ grain, may be necessary, but should be used cautiously if the patient is under the effect of other drugs.

3. As early as possible after the onset of symptoms, the following plan of administration of antitoxin is recommended. Since little time is lost by the procedure, 1 c.c. of antitoxin is injected subcutaneously to desensitize the patient. If no anaphylactic symptoms, such as dyspnea, cyanosis or rapid, feeble pulse occur, 20,000 units of antitoxin are given intravenously thirty minutes later. The gravity method is preferred, a large glass syringe barrel being used as the container, to which is attached about 15 inches of rubber tubing for the needle connection. The rubber tubing should not be new because of poisonous symptoms which sometimes occur as the result of soluble toxic substances present in new rubber. If new rubber tubing is to be used, it should be thoroughly washed for half an hour in a 5 per cent. sodium hydroxid solution before boiling. The needle should be of 19-18 gage and about 1½ inches long. It should be threaded its entire length into the vein in order to avoid accidental removal during injection. The antitoxin should be diluted with an equal volume of warm physiologic sodium chlorid solution and should be maintained at as near body temperature as possible. The first 10 c.c. should be allowed to flow in slowly at a rate of about 1 c.c. a minute. If symptoms of anaphylaxis occur, one should discontinue the injection and try again in three hours, since the patient has probably been desensitized by the amount of serum previously received.

4. After the intravenous dose, 20,000 units should be given intraspinally (10,000 units for children). The lumbar puncture should be done in the ordinary way, 0.5 per cent. procain or 1.5 per cent. solution of apothesin being employed. If the

9. Robertson, H. E.: Am. J. M. Sc. **152**:31 (July) 1916.
10. Park, W. H., and Nicoll, Matthias, Jr.: Experiments on the Curative Value of the Intraspinal Administration of Tetanus Antitoxin, J. A. M. A. **63**:235 (July 18) 1914.
11. Nicoll, Matthias, Jr.: Intraspinal Administration of Antitoxin in Tetanus, J. A. M. A. **64**:1982 (June 12) 1915.

patient is in opisthotonos, one should not attempt to perform the lumbar puncture without general anesthesia because of the danger of breaking the needle. From 10 to 25 c.c. of spinal fluid is allowed to escape through the needle. A portion is sent to the laboratory for Wassermann report and microscopic examination, including cell count. The antitoxin, which need not be diluted but which should be warmed to body temperature, should be allowed to flow in by gravity, a container similar to that described for intravenous injection being used.

5. Necrotic tissue should be cleaned out of any existing wound and the wound treated surgically. If an unhealed wound exists, it should be incised under local anesthesia, explored for foreign bodies, and curetted. Five thousand units of antitoxin are then injected into the tissues about the wound. The wound should be left open and a sterile dry dressing applied.

6. During the second day, and on the third day, 20,000 units are given intravenously, and 20,000 units intraspinally.

7. In order to continue the antitoxic effect, a subcutaneous or intramuscular injection of 10,000 units should be given on the eighth or ninth day.

8. The total dosage used for adults will approximate 125,000 units. Relatively, children will require larger dosage than adults, it being a question of neutralization of toxin and not of body weight.

ANAPHYLAXIS AND OTHER SEQUELAE

It is believed that the danger of serum sickness and anaphylactic shock has been overestimated. The British war statistics showed that 2 per cent. of the patients given intraspinal injections of antitoxin, 6 per cent. of those given intravenous injections, 1.2 per cent. of those given intramuscular injections and 0.2 per cent. of those given subcutaneous injections developed anaphylactic shock. Because of this experience, the British committee for the study of tetanus did not recommend the intravenous method of injection.

Only one instance of shock followed the intravenous injection of antitoxin in the series of forty-nine patients here reported. No mention was made in the record of prior desensitization or other precautions, such as the slow injection of the first 10 c.c., so that comment is difficult. The patient promptly recovered from shock on the injection of 10 minims of epinephrin chlorid solution. From experience during the war service in which thousands of injections of antiserum were given intravenously in the treatment of pneumonia and meningitis, it is believed that the danger of anaphylactic shock in tetanus following intravenous injection of antitoxin is not to be compared with the danger of withholding from patients the benefits possible from its use. Should symptoms of shock occur, an injection of atropin, from $\frac{1}{100}$ to $\frac{1}{75}$ grain, or 15 minims of epinephrin chlorid solution (1:1,000) usually quickly relieves the condition. So-called thermal reactions following the intravenous injection of any serum may occur immediately or within an hour. Such reaction is manifested by a chill and fever, which lasts usually for two or three hours.

Serum rashes may be expected about the eighth or tenth day in approximately 40 to 50 per cent. of those who have received antitoxin. The rash takes the form of an erythematous urticaria. It usually quickly subsides on the intravenous injection of calcium lactate, $\frac{3}{4}$ grain. This may be repeated every six to eight hours, if necessary.

An occasional instance of acute so-called serous meningitis as a manifestation of anaphylactic reaction may follow the injection intravenously of any alien serum. Berghausen [12] has recently reported such an incident. It occurred in two patients of this series. Recovery usually promptly occurs when the cerebrospinal pressure is relieved by lumbar puncture.

CONCLUSIONS

1. The most important factor in the treatment of tetanus is its prevention. It should be the universal rule to give a prophylactic dose of 1,500 units of antitoxin to all patients who have received lacerated or penetrating wounds. If the wound contains necrotic tissue or a suspected foreign body, the dose should be repeated in ten days and subsequently if operation on the wound is contemplated.

2. Treatment of all extensive lacerated wounds surgically by primary excision and primary or delayed suture will greatly reduce the incidence of the disease.

3. The incubation period of the disease is usually about ten days, but may be as short as three days. So-called tardy tetanus may occur months after an injury, if the wound is subsequently reopened.

4. The shorter the incubation period before symptoms, the greater will be the probable mortality. But little difference occurs in mortality whether the wound focus involves the lower or the upper extremity.

5. The type of infection appears to vary in virulence in different years. In four different years between 1916 and 1921, the mortality varied from 14.3 to 71 per cent. in a comparable number of patients each year, and with the same general plan of treatment.

6. When symptoms of the disease have appeared, the attempt should be made to saturate the patient with antitoxin before fixation of toxin has occurred in the nerve cells of the spinal cord. This can best be accomplished by intraspinal and intravenous injections during the first three days of treatment; the total dosage, of which half should be given intraspinally, should approximate 125,000 units.

ABSTRACT OF DISCUSSION

DR. ABRAHAM ZINGHER, New York: Dr. Park asked me to draw your attention to the fact that experimentally in guinea-pigs the intraspinal injection of tetanus antitoxin has proved superior to intravenous injection; and the intravenous injection is far superior to the intramuscular injection. For that reason he recommends that a combined intraspinal and intravenous injection be given to flush out any toxin which may be lodged there, or in the tissues themselves. He recommends from three to four injections, one injection to be given every four hours; and with the first lumbar puncture he recommends an intraspinal injection of about 12,000 units of tetanus antitoxin. Those are the main points to which he wanted me to draw your attention. The tetanus antitoxin is sometimes viscid and must be diluted with salt solution so as to diffuse more readily into the spinal canal. I want to call attention to the various forms of tetanus which may occur. You are familiar with the acute form. The irregular and neurologic form may resemble hydrophobia or trismus. Unilateral tetanus of one arm or one leg, or chronic insidious tetanus, may puzzle one in the diagnosis. However, these forms are rather rare, and the prognosis is, as a rule, good.

DR. RICHARD H. MILLER, Boston: At the Massachusetts General Hospital there have been 116 cases in the last fifty years. The mortality has fallen steadily year by year. The total mortality was 70 per cent. Since 1896 we have had ninety-six cases with a mortality of 67.7 per cent.; since 1910, forty-five cases with a mortality of 57.8 per cent.; since 1916, twenty-five cases, with a mortality of 52 per cent. Of our

12. Berghausen, Oscar: Serous Meningitis Following Injection of Antitetanic Serum, J. A. M. A. 73: 1841 (Dec. 13) 1919.

last five cases, recovery occurred in three. We have had ten cases in which the incubation period was less than ten days. The patients recovered. There is no way of explaining this, except that the infecting organism happened to be of a nonvirulent strain. There is not much difference between Dr. Stone's method of treatment and our own, except that we administer more antitoxin intravenously and less intraspinally. It is our custom, on the entrance of a patient, to give 10,000 units intraspinally and follow this with an intravenous dose of from 30,000 to 40,000 units. We repeat the intraspinal injection every day for three days and the intravenous dose twice a day for four or more days. In the average case in an adult we give at least 200,000 units in all. We also inject a small amount around the wound at the time of entrance. As to the treatment of the wound: It seems to us, as Dr. Stone has said, that it should be cleaned thoroughly and every bit of necrotic tissue removed. He applies a bandage, but we do not. I think that once in a while, if all the necrotic tissues are not removed, a tight bandage may produce a certain degree of anaerobiosis. We leave the wound open to the air and lightly covered with gauze impregnated with hydrogen peroxid.

We, too, have used phenobarbital (luminal), and I am convinced that it is doing a certain amount of good. The problem we have to solve is how to get the antitoxin in contact with the toxin already in the tissues of the central nervous system. Almost everybody agrees that the intraspinal method is the one method which should be used. Theoretically, it is hard to explain. The toxin ascends to the central nervous system, the axis cylinder and the perineural lymphatics and becomes impregnated in the cells. If antitoxin is given intraspinally, it comes in contact with the meninges, and, according to English observers, it is absorbed therefrom and enters the circulation. Our problem is to discover the way in which we can make the antitoxin reach the affected parts of the central nervous system in the same way that the toxin does. I have had only one case of anaphylaxis, and that was not marked and ceased when we stopped the injection.

DR. ALEXANDER LAMBERT, New York: I was assistant to Dr. Park from 1895 to 1902, and had charge of his tetanus work. I saw between eighty and ninety cases of tetanus in civil life. Dr. Stone did not stress the necessity of getting these patients to quiet down so that the tetanus antitoxin could take effect. I think the phenobarbital had something to do with that. The idea of stuffing the ears with cotton is good. The first muscle in the body affected by the trismus is the rectus abdominis, and in my experience it is the last to let up. Unless you are looking for this rectus abdominis rigidity you will be deceived, and you will lose many precious hours.

DR. A. A. HEROLD, Shreveport, La.: I have had fully as good results by eliminating intraspinal treatment. How can the tetanus antitoxin reach the central nervous system when the tetanus toxin is bound up in the axis cylinders? The more rational plan is to give immense doses intravenously and subcutaneously. The intraspinal treatment does harm by putting poison in the intra-arachnoid spaces. My only excuse for the intraspinal treatment is to get relief of pressure, and in that way enable the intravenous treatment to reach the poisoned cells, and then if it is a severe case to try the intraspinal injection of magnesium sulphate, as advocated by Meltzer. In the very virulent cases one cannot expect results, no matter what treatment one employs. To my mind, giving tetanus antitoxin intraspinally is as bad treatment as giving castor oil hypodermically.

DR. W. T. COUGHLIN, St. Louis: I have some very unpleasant recollections about tetanus. We gained some unpleasant notoriety in this city twenty years ago through the contamination of the antidiphtheritic serum, and in those cases no germs were introduced. When the patient comes to the surgeon, as a rule, the patient has had as much tetanus antitoxin as he is going to get, especially if he is treated by a surgeon. The wound is excised and then the only possibility of the introduction of further poison is from that which may be present in the track between the wound and the central nervous system. If that is true, then it behooves us to get the antitoxin into the patient's system as soon as possible. In the last three years, at the city hospitals, we have been giving large doses, and I do not think we ought to be afraid to give large doses. I have not seen anything happen which I could in any way attribute to the size of the dose which the patient received. We have had much better success since we began to use the large doses. A child of 15 years is given 50,000 units in four different ways, intraspinally, subcutaneously, intramuscularly and intravenously. Usually, that daily dosage is divided into about four doses so that a dose is given every six hours; first, intraspinally, and then intravenously. On the second day it is increased by half until the dose climbs up pretty high, and I think that this ought to be continued until the patient is dead or well. In the cases in which we have been able to use the most serum, the results have been most gratifying; but I do not see why we should wait three or four days if the patient is not worse; if he is not any better, we ought to give larger doses of antitoxin. There is a difference in virulence of the organism and in the personnel of those attending the patient, and in their manner of dealing with the patient, which must be considered. I would not insist on giving antitoxin intraspinally. I think it will get to the central nervous system through the blood channels just as well as by injecting it into the subdural space.

DR. MARY FREEMAN, Perrine, Fla.: I have had three cases of tetanus. The first I saw on the eighth day. A boy ran a sliver into his toe. I was called to treat him for throat trouble, and found rigidity of the jaw. I was unable to get his mouth open. I sent him to the hospital 17 miles away, but he died the following day. The second case was a child of 3 who had spells. I suspected tetanus and on inquiry learned that he had stepped on a nail two days before. I took him immediately to a hospital 20 miles away. He recovered. His little sister stepped on a nail two days later. They brought her in on the fifth day. She was very nervous. The question arose whether it was tetanus. I found the knee jerk exaggerated in the knee on the same side as the foot into which she had run the nail. She recovered.

DR. WILLARD J. STONE, Pasadena, Calif.: In connection with chronic tetanus, which is not uncommon, and which is characterized by twitching of the muscles, usually of the extremities, it is worth while to remember at this time, when we are seeing patients with encephalitis, that myoclonic twitchings of the muscles of the abdomen or limbs and extremities may occur in these cases. Many of those patients are conscious just as the tetanus patients are conscious, and it may require great discretion to make the proper diagnosis and inaugurate the proper treatment. In connection with the dosage of antitoxin for children, as compared with adults, it is not a question of body weight but of neutralization of the toxin. Consequently, children should have relatively larger doses of the antitoxin than adults. In connection with the intraspinal treatment, Dr. Park's experimental work showed, I think, quite conclusively, that animals recovered much more promptly after intraspinal injection than by any other method. At the beginning of the war the British War Office appointed a commission for the study of tetanus. Professor Cherrington, a well known physiologist of Oxford, was a member of the commission. He completely confirmed the work of Dr. Park. After saturating the patient with antitoxin, there seems to be little advantage in carrying on the treatment with large doses after the fourth day. We should urge a prophylactic injection of tetanus antitoxin for every wound, however trivial, which comes in contact with street dirt.

Another Natural Enemy of the Mosquito.—Two Lyons scientists, Riel and Bonamour, have recently rediscovered that a certain insect of the reduvioidea type feeds avidly on mosquitoes, darting to capture them on walls and ceilings. The insect, *Emesodema domestica*, is common in southern France, and the scientists are warning people not to kill them as they will aid in extermination of mosquitoes. Scopoli in 1788 mentioned that these insects fed on mosquitoes. The common name for the bug in France is the *ploière*.

RESULTS OF ACTIVE IMMUNIZATION WITH DIPHTHERIA TOXIN-ANTITOXIN

IN THE PUBLIC SCHOOLS OF NEW YORK CITY (MANHATTAN AND THE BRONX) *

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In a previous communication [1] in THE JOURNAL, we reported the results of the Schick tests which had been made between February and June, 1921, in forty-four public schools in the boroughs of Manhattan and the Bronx. A total of more than 52,000 schoolchildren had been tested, and those giving positive reactions injected with two doses, each 1.5 c.c. of toxin-antitoxin.[2]

The results of the Schick test are interesting in showing great variations in susceptibility to diphtheria among the children of different schools. We found that the children from the homes of the more well-to-do gave a much greater percentage of susceptible individuals than the children from the homes of the poorer classes of the population. In the schools located in the better sections of the city and attended largely by children of the first group, the positive reactors ranged as high as from 50 to 70 per cent.; while in other schools located in the more crowded sections only from 16 to 25 per cent. gave a positive Schick reaction. Segregation and relative isolation of the children of the more well-to-do, crowding and frequent exposure to infection with the diphtheria bacillus of the children of the poorer classes offered the most probable explanation for these variations in susceptibility.

The hereditary family factor and the racial factor, although less important, also seem to have a bearing on the results. Thus, we found that a group of children belonging to one family often gave entirely different Schick reactions from a group of children belonging to another family but living under the same conditions and surroundings. In some of these families the tendency to a negative Schick reaction showed itself quite early in life. It was seen in the younger children as soon as they became 2 or 3 years of age, while all the older children in the same families already gave a negative reaction. On the other hand, there were families in which all the children, including the older ones, showed a well pronounced positive reaction.

The racial influence was seen in the relatively high proportion of positive Schick reactions among the colored children and the unusually low proportion of positive reactions among the children of Italian parents.

It will be interesting now to see what contrast is found between the children of the more well-to-do and those of the poorer classes in their production of an active antitoxic immunity in response to the injections of toxin-antitoxin.

MIXTURES OF TOXIN-ANTITOXIN

From the very beginning of this work, Dr. Park and I have realized that the composition and the character of the toxin-antitoxin mixture play an important part in the efficiency of the immunity response. Two standards can be established for these mixtures: (*a*) a standard of safety, and (*b*) a standard of efficiency.

The standard of safety is complied with when 5 c.c. of a mixture of toxin-antitoxin injected into a guinea-pig produces a pronounced local induration and late paralysis in the animal, but not acute death from diphtheria toxemia. Such a mixture was used as a rule in our work in the public schools. In some of the schools, however, we used a slightly more toxic mixture, which produced paralysis in the guinea-pig in doses of 3 c.c., 2 c.c. and even 1 c.c. Under no condition, however, was a mixture given which produced acute death of the guinea-pig in doses of even 5 c.c.

The standard of efficiency is one which is much more difficult to establish. We learned in our earliest work that mixtures of toxin-antitoxin that were overneutralized or just neutral were not as effective in producing active immunity as the slightly toxic mixtures. The margin of toxicity in a mixture that would be still safe for use in human beings remained to be investigated. A second problem that called for study was the question whether a mixture made of a more potent toxin and containing from five to six L + doses of toxin to each cubic centimeter was more effective in its immunizing properties than the one containing three L + doses of toxin to each cubic centimeter, the two mixtures having the same free margin of toxicity. The mixture with 3 L + doses and 3.5 units of antitoxin has been used extensively up to the present time. Dr. Banzhaf of the Research Laboratory prepared at the suggestion of Dr. Park several mixtures of toxin-antitoxin of slightly varying toxicity, containing from three to five L + doses of toxin to each cubic centimeter. These mixtures were used in the different schools. For a better understanding of the results obtained in the schools, Table 1 is presented.

Table 1 gives the mixtures used, the number of L + doses per cubic centimeter, and the toxicity as shown in the guinea-pig test. The schools in which each mixture was used are indicated, and comment is made whether each mixture was injected as originally prepared or whether it had to be adjusted subsequently. Some of the mixtures were either overneutralized or too toxic, and consequently more toxin or more antitoxin had to be added.

Mixtures 23, 24, 35 and 36 contained in each cubic centimeter three L + doses of toxin and 3½ units of antitoxin. Mixtures 37 and 38 contained in each cubic centimeter five L + doses of toxin and about 6 units of antitoxin. Notwithstanding the different proportions, it will be seen that there was quite a strong similarity in the toxicity of the different mixtures, as shown in their paralyzing effect on the guinea-pig. Mixtures 36 and 38 were slightly more toxic than the others.

In our previous work in various institutions we had found that certain mixtures were very effective in producing an active antitoxin immunity in a high percentage of injected individuals. Such mixtures were in all tests quite similar in toxicity and L + strength to other mixtures, which gave a much poorer immunity

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* Read before the Section on Diseases of Children at the Seventy-Third Annual Session of the American Medical Association, St. Louis, May, 1922.

1. Zingher, Abraham: Diphtheria Prevention Work in the Public Schools of New York City, J. A. M. A. 77:835 (Sept. 10) 1921.

2. The Schick work in the schools was carried out under the general direction of Dr. William H. Park and in cooperation with Drs. J. S. Baker, Jacob Sobel and J. L. Blumenthal of the Bureau of Child Hygiene, and Dr. Louis I. Harris of the Bureau of Preventable Diseases of the Department of Health. Dr. I. H. Goldberger, of the Bureau of Educational Hygiene of the Department of Education, was largely instrumental in obtaining permission for us to do the work in the different schools. I also wish to acknowledge the valuable assistance of my co-workers, Drs. I. O. Bloom, Anna Weintraub, Thomas F. Cooney, M. Harrison, S. Schwadron, Mr. William Abrams and Miss Leah Alper.

response. Many confusing questions arose as to the reasons for these variations in immunizing efficiency of different mixtures of toxin-antitoxin. The experience, therefore, gained in the active immunization of the large number of public school children will be of value in interpreting and answering some of these very interesting and important questions.

NUMBER OF DOSES AND AMOUNT OF TOXIN-ANTITOXIN

The children received, as a rule, two doses, each 1.5 c.c., at intervals of seven days. We wished to see whether two doses of 1.5 c.c. would be the equivalent of three doses of 1 c.c. formerly given. If one injection of toxin-antitoxin could be eliminated, the work in the schools would be greatly facilitated. The results given in the following tables show, however, that two doses of 1.5 c.c. are not as effective as three doses of 1 c.c. Three doses, therefore, should be the minimum number of injections in actively immunizing an individual with toxin-antitoxin.

however, in the mind of the observer as to the absolute certainty of the interpretation of such a reaction unless he makes a control and is able to compare the reactions on the two forearms.

The necessity of careful and accurate dilution of the unheated bulk toxin for the Schick test and of the heated toxin for the control test has been emphasized in a previous publication.[3]

TRANSIENT AND PERSISTENT PSEUDOREACTIONS

We had noted in our work that a few of the schoolchildren who had given a simple positive Schick test showed a moderately pronounced local reaction after the injections of toxin-antitoxin. The question, therefore, presented itself whether these children might have had a pseudo-element combined with their positive reactions that was transient, disappeared after forty-eight hours and was not noted in the final reading, which was made from the fourth to the seventh day after the test. A detailed study of the Schick test and of the control test was therefore undertaken in one of

TABLE 1.—RESULTS OF TESTS IN GUINEA-PIGS WITH MIXTURES OF TOXIN-ANTITOXIN

Mixture T-A	Composition of Mixture	Date of Test	Amount Injected, C.c.	Result in Guinea-Pig	Public Schools in Which Mixture Was Used	Comment
23	In each c.c., 2 L+ doses toxin and 3½ units antitoxin	1/14/21	2.0	Induration; paralysis in 20 days	161, 57, 103M, 186, 122	Mixture originally prepared was too toxic; additional amounts of antitoxin had to be added 3 times to reduce the toxicity to a safe point
		1/14/21	3.0	Induration; paralysis in 18 days		
		1/10/21	5.0	Induration; paralysis in 21 days		
24	In each c.c., 2 L+ doses toxin and 3½ units antitoxin	1/20/21	2.0	Induration; paralysis in 19 days	90	Mixture used as originally prepared; no further addition of toxin or of antitoxin needed
		1/20/21	3.0	Induration; paralysis in 18 days		
		1/20/21	4.0	Induration; paralysis in 20 days		
		2/ 1/20	5.0	Induration; paralysis in 20 days		
		5/ 6/20	5.0	Induration; paralysis in 21 days		
		8/ 7/20	5.0	Induration; paralysis in 21 days		
35	In each c.c., 2 L+ doses toxin and 3½ units antitoxin	1/14/21	2.0	Induration; paralysis in 19 days	168, 20, 169, 43Br., 46, 15, 157	Mixture originally prepared was slightly overneutralized; small amount of toxin had to be added to bring it up to suitable toxicity (12/15/20)
		1/14/21	3.0	Induration; paralysis in 19 days		
		1/14/21	4.0	Induration; paralysis in 19 days		
		1/14/21	5.0	Induration; paralysis in 18 days		
36	In each c.c., 3 L+ doses toxin and 3½ units antitoxin	3/17/21	1.0	Induration; paralysis in 21 days	102, 172, 78, 83, 39G., 39B., 64, 40, 171, 61, 84, 85, 96, 89, 62	Mixture originally prepared was overneutralized; additional amounts of toxin added at 3 different times between 2/1 and 3/8/21
		5/29/21	3.0	Induration; paralysis in 18 days		
		3/10/21	5.0	Died in 22 days		
37	In each c.c., 5 L+ doses toxin and 6 units antitoxin	3/10/21	5.0	Induration; paralysis in 19 days	103	Mixture originally prepared was too toxic; more antitoxin added 3/10/21
		3/10/21	5.0	Induration; paralysis in 21 days		
38	In each c.c., 5 L+ doses toxin and 6 units antitoxin	4/ 4/21	0.5	Induration; paralysis in 20 days	19, 188G., 188B., 159, 29, 42Br., 54Br., 54M., 77, 52Br., 5, 158, 11Br., 68	Mixture originally prepared was too toxic; additional antitoxin added 3/30 and 4/2/21, then refiltered through Berkefeld filter
		4/ 4/21	2.0	Induration; paralysis in 20 days		

THE NECESSITY OF A CONTROL IN THE SCHICK TEST

We were greatly impressed in this work by the fact that the children who had the most pronounced local and constitutional symptoms after injections of toxin-antitoxin were the ones who had given a positive-combined Schick reaction. The number of children showing such severe reactions would have been multiplied several times if we had not previously carefully excluded those who had a negative pseudoreaction. We were able to do this by giving each schoolchild a control test with heated toxin. In some of the schools, fully 25 to 30 per cent. of the children gave a negative pseudoreaction. Many of these would have been considered positive or doubtful without a control test, and would have shown the usual severe local and constitutional symptoms after the injections of toxin-antitoxin.

Children under the age of 5 years seldom have pronounced negative pseudoreactions, but those of school age and especially the elder among these children frequently do so. A negative pseudoreaction can be interpreted occasionally with fair accuracy without a control test. There will always remain some doubt, the schools. Comparisons were made between the various reactions of the Schick test and the severity of the local and constitutional symptoms following the injections of toxin-antitoxin.

The Schick test with the unheated toxin was made on the right forearm, and the control test with the heated toxin on the left forearm. Observations of the reactions were made at the end of twenty-four hours and again at the end of five days to see how many children had a transient and how many a more persistent pseudo-element in their reactions.

In the preliminary Schick test readings at the end of twenty-four hours the reactions were interpreted temporarily as follows: (*a*) A slight or moderate redness on the right or test forearm, with no redness on the control forearm, was considered a positive reaction; (*b*) no redness on either forearm, a negative reaction; (*c*) an area of redness on both forearms, which was equal in size and similar in appearance, was considered a negative pseudoreaction; (*d*) an area of redness on both forearms, but unequal in size, the one on

3. Zingher, Abraham: The Schick Test: Standardization of Diphtheria Toxin for the Test and of Heated Diphtheria Toxin for the Control; Methods of Diluting the Toxin, J. A. M. A. 78: 490-493 (Feb. 18) 1922.

the right side being larger, said to be a positive combined reaction.

In the final reading of the Schick tests at the end of five days, the reactions were read as follows: positive, if there were a definite, well-pronounced red area on the right or test forearm and no redness or pigmentation on the left or control forearm; negative pseudo, if there were a fading brownish or reddish brown area of pigmentation, not sharply circumscribed as a rule, but equal in size and similar in appearance on the two forearms; positive combined, if there were a typical positive reaction on the right or test forearm, and a faded pseudo-like reaction on the left or control forearm.

TABLE 2.—EARLY AND LATE SCHICK TEST READINGS AT PUBLIC SCHOOL 19, MANHATTAN

	Schick Test Readings at		Number		Per Cent. of Total Tested
	24 Hours	5 Days		Total	
Group 1. Immunes:					
A. With no pseudoreaction	Negative	Negative	57	57	14.4
B. With transient pseudoreaction	Negative pseudo	Negative	73	75	19.3
	Positive combined	Negative	2		
C. With persistent pseudoreaction	Negative pseudo	Negative pseudo	129	138	34.9
	Positive combined	Negative pseudo	9		
Group 2. Nonimmunes:					
A. With no pseudoreaction	Positive	Positive	67	80	20.3
	Negative	Positive	13		
B. With transient pseudoreaction	Negative pseudo	Positive	16	35	8.9
	Positive combined	Positive	19		
C. With persistent pseudoreaction	Negative pseudo	Positive combined	6	11	2.8
	Positive combined	Positive combined	5		
Total tested				396	

Table 2 shows the foregoing children divided into two groups. In Group 1, immunes, under A, it will be seen that fifty-seven out of 396 children, or 14.4 per cent., had a negative Schick reaction at the end of twenty-four hours, which persisted as negative on the fifth day.

B. Seventy-five children, or 19 per cent., had a pseudo-element in their reactions which was noticeable in the twenty-four hour reading, but had disappeared completely on the fifth day, so that the reactions were read as simple negative.

C. One hundred and thirty-eight children, or 34.9 per cent., had a pseudoreaction at the end of twenty-four hours, which persisted on the fifth day, the reactions being read as negative pseudo.

In Group 2, nonimmunes, the table shows under A, eighty children, or 20 per cent., who had either a positive or a negative reaction at the end of twenty-four hours, which appeared positive on the fifth day. It is important to note in this group that in twelve of the children the positive reaction had not yet appeared at the end of twenty-four hours. These slowly developing positive Schick reactions are an additional indication not to make a final reading of the tests before the fourth or fifth day.

B. Thirty-five children, or 8.9 per cent., had a transient pseudo-element in their reactions, which was noticeable at the end of twenty-four hours, but disappeared on the fifth day, so that the reactions were read as positive.

C. Eleven children, or 2.8 per cent., had a pseudoreaction at the end of twenty-four hours, which persisted on the fifth day, the reactions being read as positive combined.

It should be stated that the transient pseudoreactions, which were seen at the end of twenty-four hours, but had faded completely on the fifth day, appeared at the earlier reading only as slight areas of redness with little if any induration. Such transient pseudoreactions indicate a slight or moderate susceptibility to the proteins of the toxin-antitoxin mixture, while the persistent pseudoreactions indicate a much more marked susceptibility to these proteins. These facts are brought out in Table 3.

Table 3 shows the results of a study made on four groups of children of the relation of toxin-antitoxin injections and the pseudo-element in the Schick test. The groups consisted of: (*a*) children showing no pseudo-element; (*b*) a transient pseudo-element; (*c*) a persistent pseudo-element, and (*d*) a group in which no preliminary twenty-four hour reading was made.

The local reaction at the site of the injection of toxin-antitoxin was classified according to its intensity as slight, moderate or marked. A reaction was considered slight, if it showed only a small area of redness and slight infiltration varying in size from a fifty cent piece to a silver dollar; moderate, if it showed a larger area of redness with more induration and tenderness, and marked, if it showed an extensive and diffuse area of redness and infiltration involving one half or more of the arm with slight swelling and tenderness of the axillary glands. The children having marked reactions complained, as a rule, of pain and soreness in the arm.

TABLE 3.—REACTIONS AFTER INJECTIONS OF DIPHTHERIA TOXIN-ANTITOXIN AT PUBLIC SCHOOL 19, MANHATTAN

Schick Test Reading at		Reactions After Toxin-Antitoxin				Per Cent.	
24 Hours	5 Days	Slight	Moderate	Marked	Total	Slight	Moderate	Marked
Group 1. With No Pseudoreaction								
Positive	Positive	61	6	0	67			
Negative	Positive	12	1	0	13			
Total		73	7	0	80	93.6	8.4	0
Total per cent. moderate and marked reactions after toxin-antitoxin injections							8.4	
Group 2. With Transient Pseudoreaction								
Negative pseudo	Positive	11	4	1	16			
Positive combined	Positive	11	8	0	19			
Total		22	12	1	35	62.8	34.2	3.0
Total per cent. moderate and marked reactions after toxin-antitoxin injections							37.2	
Group 3. With Persistent Pseudoreaction								
Negative pseudo	Positive combined	1	3	2	6			
Positive combined	Positive combined	0	1	4	5			
Total		1	4	6	11	9.2	36.3	54.5
Total per cent. moderate and marked reactions after toxin-antitoxin injections							90.8	
Group 4. With No 24 Hour Reading								
(a) Not read	Positive	28	0	0	28	100.0		
(b) Not read	Positive combined	0	4	2	6	.....	66.6	33.3
Total per cent. moderate and marked reactions in positive combined after toxin-antitoxin injections							100.0	

It is interesting to note in Group 1, in which the pseudo-element was lacking in the Schick reaction, that seventy-three out of eighty, or 93.6 per cent., had a slight toxin-antitoxin reaction, only seven, or 6.4 per cent., a moderate reaction, and none a severe reaction.

In Group 2, in which there was a transient pseudo-element in the Schick reaction, 34.2 per cent. gave a

moderate and 3 per cent. a marked toxin-antitoxin reaction, a total of 37.2 per cent.

In Group 3, in which there was a persistent pseudo-element in the Schick reaction, fully 36.3 per cent. gave moderate, and 54.5 per cent. marked toxin-antitoxin reactions, a total of 90.8 per cent. Only one child in this group had a slight toxin-antitoxin reaction.

In Group 4, no preliminary reading of the Schick reactions was made at the end of twenty-four hours, and only a final reading on the fifth day. All the twenty-eight children whose tests were read simply as positive gave only a slight reaction, while each of the six children whose tests were read as positive combined gave moderate or marked reactions to the injections of toxin-antitoxin.

The following conclusions can be drawn from the results given in the two tables:

1. A final reading of the Schick tests should not be made before the fourth or fifth day. The reactions will then be read with much greater accuracy. The slowly appearing positive reactions will be clearly seen; the negative pseudoreactions will have faded to a large extent, and the small number of positive combined reactions will be more clearly differentiated from the negative pseudoreactions.

2. Many of the children showing negative pseudoreactions who might be considered as having a positive or doubtful Schick reaction without a control test and injected with toxin-antitoxin will be eliminated from receiving the injections if a control test is made at the same time as the Schick test.

3. For all practical purposes, the single final reading of the Schick test after the fourth day is sufficient to indicate (*a*) those children who will have only a slight reaction (positive Schick reactors) or (*b*) those who will have a more pronounced reaction (positive combined Schick reactors) after the injection of toxin-antitoxin.

4. For the accurate reading of the reactions, it is necessary that the control test be considered as an integral part of the Schick test, without which the test is incomplete. This is especially true for Schick tests made in children over 5 years of age.

SCHICK RETESTS TO DETERMINE EFFICIENCY OF TOXIN-ANTITOXIN IMMUNIZATION

The children of twenty-two schools in which Mixtures 23, 35, 36 and 37 were used were retested in the spring from two to three months after the injections of toxin-antitoxin. The children of Public School 90, in which we gave three doses of Mixture 24, were retested after five months. The remaining nine schools in which Mixture 36 was used, and all the schools immunized with Mixture 38, were retested in the fall from four to seven months after the immunizing injections.

Mixture 38 was used for reinjecting all the children who had not become immune in the twenty-three schools retested in May and June. Fifteen of these schools were retested a second time in the fall at intervals of from seven to nine and one-half months after the first series of toxin-antitoxin injections.

RESULTS OF FIRST SCHICK RETEST

Tables 4 and 5 give the immunity results obtained in the different schools. The tables also show the number of children originally tested in each school and the percentage of positive Schick reactors.

Table 4 shows the public schools retested in the spring from two to three months after the injections of toxin-antitoxin.

Table 5 gives the schools retested in the fall. Group 7 in this table is an exception, in that it was originally tested in December, 1920, and retested after five months in May, 1921.

TABLE 4.—RESULTS OF ACTIVE IMMUNIZATION WITH DIPHTHERIA TOXIN-ANTITOXIN: FIRST SERIES OF SCHICK RETESTS AFTER FROM TWO TO THREE MONTHS

Public School	Location	Original Schick Test: Total Tested	Original Schick Test: Per Cent. Positive	First Schick Test: Months After Tox.-Ant.	First Schick Test: Total Re-tested	First Schick Test: Per Cent. Negative
Group 1. Toxin-Antitoxin Mixture 23; Two Doses, 1.5 C.c. Each						
101	111th Street and Lexington Ave.	968	29.7	3.0	152	70.0
57	113th Street and Third Avenue	1,368	25.9	3.0	234	64.5
43 M.	129th Street and Amsterdam Ave.	763	37.6	3.0	183	63.0
186	145th Street and Broadway	824	55.8	3.0	291	39.9
132	182d Street and Wadsworth Ave.	768	50.2	2.5	213	27.7
Group 2. Toxin-Antitoxin Mixture 35; Two Doses, 1.5 C.c. Each						
168	104th Street and Second Avenue	1,569	17.7	2.5	213	82.7
20	Rivington and Eldridge Streets	1,540	20.8	2.5	217	52.0
43 Br.	135th Street and Brown Place	1,966	28.5	2.5	397	35.2
15	Fourth Street and Avenue D	1,192	29.0	2.5	266	30.0
169	169th Street and Audubon Avenue	825	45.9	2.5	269	25.2
46	138th Street and St. Nicholas Ave.	960	55.3	2.5	302	25.0
157	126th Street and St. Nicholas Ave.	961	38.3	2.5	253	21.3
Group 3. Toxin-Antitoxin Mixture 36; Two Doses, 1.5 C.c. Each						
102	118th Street and Second Avenue	1,687	17.5	2.5	187	63.8
172	106th Street and Second Avenue	1,540	18.4	2.5	197	52.8
78	119th Street and Pleasant Ave.	1,967	22.1	2.5	249	49.4
83	109th Street and Third Avenue	2,349	13.6	2.5	204	42.6
39 G.	125th Street and Second Avenue	981	26.1	2.5	167	40.7
39 B.	126th Street and Second Avenue	847	18.5	2.5	111	37.8
64	9th Street and Avenue B	1,655	19.0	2.5	115	32.0
40 Br.	Prospect Ave. and Jennings Street	1,895	41.8	2.5	561	27.4
171*	166d Street and Madison Avenue	1,866	22.2	2.5	280	24.5
Group 4. Toxin-Antitoxin Mixture 37; Two Doses, 1.5 C.c. Each						
103	119th Street and Madison Avenue	1,363	28.4	2.5	298	50.0

* In this school, 79 per cent. of children tested were over 10 years of age. This accounts for the low percentage of positive Schick reactions in the original test.

A detailed study of these two tables shows the following points of interest:

1. The same mixture of toxin-antitoxin showed a marked variation in its immunizing powers in the different schools in which it was used. This variation ranged from 20 to 60 or 70 per cent. of successfully immunized children.

We were at first considerably surprised by the great difference in the immunity response noted in different schools with the same mixture of toxin-antitoxin. Since each mixture showed such variations within its group of schools, we finally concluded that the difference could not be ascribed to the individual mixture, but had to be attributed rather to variations in the groups of injected children. We were led to this conclusion by a closer study of the individual schools in each group. We compared the immunity results

obtained with the percentage of susceptible children found at the original test in the same school, and were impressed by a remarkable relation between the figures in the two percentage columns. Table 4 shows especially well the *inverse ratio* between the percentage of susceptible children in a school and the percentage of children who became immune after the first series of toxin-antitoxin injections. The higher the percentage of positive Schick reactions in a school, the poorer, as a rule, was the response to the injections of toxin-antitoxin, and the lower the percentage of negative Schick retests. The lower the percentage of positive reactions in a school the better the response to the toxin-antitoxin injections and the higher the percentage of negative Schick retests.

One conclusion seems to be justified from these results. The schools in which a large proportion of the children are "naturally" immune, schools located in the crowded sections of the city, have in their positively reacting children individuals who have already been exposed by frequent contact to infection with the diphtheria bacillus. Although these children have not yet acquired a "natural" antitoxic immunity, yet their cells have already been partly stimulated by these exposures. When the injections of toxin-antitoxin are given, these children respond quite readily to the immunizing impulse and produce a sufficient amount of antitoxin to show a negative Schick retest. On the other hand, in schools in which there is only a small proportion of "naturally" immune and a correspondingly high proportion of susceptible children, schools attended in cities like New York by the children of the more well-to-do classes, there will be found a large group of positively reacting children who have been very little exposed by contact and crowding to infection with the diphtheria bacillus. The cells of such children have not yet received a sufficient primary stimulation. When injected with toxin-antitoxin, these children do not respond readily to the immunizing impulse, and only a small proportion produce a sufficient amount of antitoxin to give a negative Schick retest.

TABLE 5.—RESULTS OF ACTIVE IMMUNIZATION WITH DIPHTHERIA TOXIN-ANTITOXIN: FIRST SERIES OF SCHICK RETESTS AFTER FROM FOUR TO SEVEN MONTHS

Public School	Location	Original Schick Test: Total Tested	Original Schick Test: Per Cent. Positive	First Schick Retest: Months After Tox.-Ant.	First Schick Retest: Total Re-tested	First Schick Retest: Per Cent. Negative
Group 5. Toxin-Antitoxin Mixture 36; Two Doses, 1.5 C.c. Each						
14	27th Street and Third Avenue	1,242	34.6	5.5	245	60.0
61	12th Street and Avenue B	1,387	34.7	5.5	256	60.1
84 *	50th Street and Tenth Avenue	612	36.6	5.0	110	59.0
85	115th Street and First Avenue	971	25.9	5.0	108	65.5
96	81st Street and Avenue A	1,065	32.5	5.0	195	37.4
80*	113th Street and Lenox Avenue	865	47.9	5.0	261	33.3
Group 6. Toxin-Antitoxin Mixture 38; Two Doses, 1.5 C.c. Each						
19	14th Street and First Avenue	1,485	34.1	5.0	280	65.0
188 B.	Houston and Lewis Streets	1,460	22.3	4.6	238	58.0
188 G.	Houston and Lewis Streets	1,216	20.5	4.5	251	55.3
42 Br.	Washington Ave. and Claremont Pkwy.	1,284	24.1	5.0	208	51.9
159†	119th Street and Third Avenue	1,301	19.6	7.0	144	50.7
54 Br.	Intervale Ave. and Freeman Street	1,243	38.3	7.0	262	47.0
20	16 Albany Street	258	35.2	5.0	52	46.0
54 M.	160th Street and Amsterdam Ave.	433	46.6	5.5	115	41.7
77	83d Street and First Avenue	667	42.9	5.0	197	37.0
52 Br.	Kelly Street and Avenue St. John	1,583	38.0	5.0	357	28.2
5*	140th Street and Edgecombe Ave.	1,222	45.9	5.5	215	27.9
11 Br.	169th Street and Ogden Avenue	297	67.0	5.5	106	25.4
65*	129th Street and Lenox Avenue	866	47.2	5.5	225	22.2
Group 7. Toxin-Antitoxin Mixture 24; Two Doses, 1.5 C.c. Each						
90	148th Street and Eighth Avenue	903	46.5	5.0	160	67.5

* A large proportion of children attending these schools are colored.
† In this school, 56 per cent. of children tested were over 10 years of age. This accounts for the low percentage of positive Schick reactions in the original test.

TABLE 6.—THE SCHICK TEST AND TOXIN-ANTITOXIN IMMUNIZATION IN VARIOUS INSTITUTIONS

Institution	Original Schick Test: Number of Children Tested	Original Schick Test: Schick Positive	Original Schick Test: Per Cent. Positive	Toxin-Antitoxin: No. of Doses	Toxin-Antitoxin: Amt., C.c.	Schick Retest: Mos. After Toxin-Ant.	Schick Retest: Children Re-tested	Schick Retest: Schick Negative	Schick Retest: Per Cent. Negative
St. Agnes.....	627	74	11.8	1-2	1.0	7	64	63	98.5
St. Dominic.....	760	110	14.4	2-3	1.0	12	83	82	98.5
N. Y. Juvenile Asylum.....	558	152	27.2	3	1.0	6	121	118	97.5
St. Joseph's Home.....	1,030	126	12.2	2-3	1.0	10	55	55	100.0
Hebrew Orphan Asylum.....	1,160	169	14.4	1	1.0	8	117	95	81.2

The conclusions from these observations are emphasized and confirmed by the results obtained with toxin-antitoxin immunization in different institutions as seen in Table 6. In these places we found that only a relatively small percentage of the children gave a positive Schick reaction at the original test, the large majority of the children being immune. In some institutions we found as few as from 5 to 10 per cent. who showed a positive reaction. A high proportion of negative reactions was especially noticeable in children who had been in the institution for more than six months. The constant crowding of the children in such institutions would appear to explain these findings. When the positive reactors were injected with toxin-antitoxin, fully 85 to 100 per cent. of the nonimmunes became actively immunized after the first series of injections, and gave a negative Schick retest. It is very likely that the tissue cells of the positively reacting children had previously been partly stimulated by exposure to infection with the diphtheria bacillus. As a result, a large majority promptly became immune after injections of toxin-antitoxin.

RESULTS OF SECOND SCHICK RETEST

Table 7 shows the results of a second Schick retest in the schools that had been previously retested in the spring. The children who gave at that time a positive reaction had received a second series of toxin-antitoxin injections.

1. It is interesting to note in this table that after the stimulating effect of a first series of toxin-antitoxin injections, the ratio of immunity response to the second series of injections does not follow any more the above mentioned *inverse ratio* between original susceptibility of the children in a school and the percentage of successfully immunized children. The first series of injections had stimulated the cells of all the children, though not sufficiently in some to produce the necessary amount of antitoxin for a negative Schick retest. The response of these children now to the second series of toxin-antitoxin injections varied somewhat in different schools, but the percentage of successfully immunized children was quite high in all the schools.

There were some children in whom a positive Schick reaction persisted after the second series of toxin-antitoxin injections. These were rather few in number, and were given a third series of two or three injections of toxin-antitoxin. It is important to realize that one occasionally encounters a child that is resistant to active immunization and produces very little antitoxin even after repeated series of toxin-antitoxin injections.

2. The percentage of children who became immune after three injections of toxin-antitoxin was higher than among the children who had received two injections. As indicated above, however, more than one factor enters into the immunizing efficiency of a first series of toxin-antitoxin injections. In the work we are doing in the schools at present, we give as a routine three injections of toxin-antitoxin. The total number of children who have become immune after from two to four injections of toxin-antitoxin in the different schools varies from 70 to 93 per cent.

3. A sufficient amount of time, which is probably not less than six months, must be allowed to elapse between the injections of toxin-antitoxin and the Schick retest before the immunity response of an injected group of children can be judged with accuracy. This is seen especially well in Table 7. In the column headed "First Schick Retest" is noted in each school a group of children who were injected with toxin-antitoxin in the early spring. Some of these children were retested from two to three months later, during May and June; others were retested for the first time in the fall from seven to nine and one-half months after the injections of toxin-antitoxin.

In some of the schools the percentage of children who gave a negative Schick retest in the fall was more than double that of the children who had been found immune in the spring. The results in these schools are more significant as proof of the importance of the element of time as a factor in active immunization than the results in Table 5, of the schools which had been retested in the fall but not in the spring. For comparative studies of this character it is advisable to have groups of children in the same school, who have been given the Schick test and injected with toxin-antitoxin at the same time and are later retested at various intervals of time.

4. Another point brought out in Table 7 in the column headed "Second Schick Retest" is that a large proportion of children who had failed to become immune after the first series of toxin-antitoxin injections became immune and gave a negative retest after a second series of one or two further injections. In studying the results we cannot consider simply the number of injections. The time interval is also an important factor. The immunizing impulse of the first series stimulates the tissue cells. The interval of time between the two series allows a full stimulation of the cells to take place, so that when the later injections of the second series are given, the cells are ready to give a prompt antitoxic response.

TABLE 7.—RESULTS OF ACTIVE IMMUNIZATION WITH DIPHTHERIA TOXIN-ANTITOXIN: FIRST AND SECOND SERIES OF SCHICK RETESTS AFTER FROM SEVEN TO NINE AND ONE HALF MONTHS

				First Series				Second Series					
		Original Schick Test			First Schick Retest				Second Schick Retest				Total Per Cent. Schick Negative After 2-4 T.-A. Injections
Public School	Location	Total Tested	Per Cent. Positive	Tox.-Ant.; 2 Doses; Amount, 1.5 C.c.: Mixture	Months After 1st T.-A.	Total Re-tested	Per Cent. Negative	Tox.-Ant. Mix. 38; Amt., 1.5 C.c.: Number of Doses	Months After 1st T.-A.	Total Re-tested	Per Cent. Negative		
46	156th St. and St. Nicholas Ave.	900	55.3	35	2.5 8.5	302 74	28.0 40.0	Two One	8.5 8.5	113 31	63.7 64.5		70.0
132	182d St. and Wadsworth Ave.	708	60.2	23	2.5 8.5	213 40	27.7 60.0	Two One	9.5 9.5	86 29	76.1 76.5		80.0
169	168th St. and Audubon Ave.	825	45.9	35	2.5 8.0	269 56	28.2 53.6	Two One	8.0 8.0	82 57	75.6 72.0		76.5
43 Br.	135th St. and Brown Place.	1,066	26.5	35	2.5 7.0	397 58	28.2 53.4	Two One	7.0 7.0	161 20	78.8 55.0		81.5
57	115th St. and Third Ave.	1,368	25.9	23	3.0 7.0	254 51	64.5 72.5	Two One	7.0 7.0	55 8	78.2 75.0		90.0
168	164th St. and Second Ave.	1,569	17.7	35	2.5 7.0	213 36	62.7 76.9	Two One	7.0 7.0	41 21	87.8 85.7		93.1
186	145th St. and Broadway.	824	55.8	23	2.5 8.0	291 37	30.7 75.7	One	8.0	60	83.3		89.5
40 Br.	Prospect Ave. and Ritter Place.	1,865	41.8	36	2.0 7.0	591 111	27.4 46.0	One	7.0	214	81.7		71.7
103	119th St. and Madison Ave.	1,363	28.4	37	2.5 9.0	256 69	60.0 69.5	One	9.0	83	86.0		84.3
39 G.	125th St. and Second Ave.	931	26.1	36	2.5 9.0	167 42	62.7 64.3	One	9.0	69	89.5		89.0
78	119th St. and Pleasant Ave.	1,587	22.1	36	2.5 8.0	249 82	50.0 62.2	One	8.0	70	75.7		82.5
171	163d St. and Madison Ave.	1,866	22.2	36	2.5 8.0	290 49	24.5 71.4	One	8.0	109	67.8		78.9
39 B.	126th St. and Second Ave.	847	18.5	36	2.5 9.0	111 31	37.8 77.4	One	9.0	30	86.6		83.5
102	113th St. and First Ave.	1,687	17.5	36	2.5 7.0	187 115	63.6 74.8	One	7.0	34	58.8		83.6

It is quite probable that there is a distinct advantage in giving the injections of toxin-antitoxin at intervals of two weeks rather than of one week.

In a previous study of "naturally" immune children and of horses known as good antitoxin producers, we had found that it requires at least seven to ten days after an injection of toxin-antitoxin before a sufficient increase in antitoxin is noted in the circulating blood to be detected by examination of the blood serum. Since the cells of such children and horses are undoubtedly sensitive and give a fairly prompt response to the injections of toxin-antitoxin, it must be assumed that it requires at least that period of time for the full effect of the immunizing injection to manifest itself. If the second injection is given within less than seven days, a good deal of its antigenic value is probably lost through breaking down in the metabolic processes of the body before it can exert its full stimulating effect on the tissue cells. Injections of toxin-antitoxin given every two weeks find the tissue cells at the height of their stimulation and therefore in the most responsive state. In the more recent schools visited we have given three injections of toxin-antitoxin at intervals of two weeks, and we intend to continue this method of immunization in the schools that will be tested this spring.

ANAPHYLAXIS

The question has been asked by many physicians as to whether there is any danger from anaphylactic shock in the injections of toxin-antitoxin. We have not seen any manifestations of anaphylactic shock after such injections either at the time of the first or of succeeding series of injections. Even an urticarial rash was rare. Only three children were reported to me who had such a rash after an injection of toxin-antitoxin. The amount of antitoxin in each dose of toxin-antitoxin is too small (from 3.5 to 6 units = $\frac{1}{200}$ to $\frac{1}{300}$ c.c.) to be of any danger even in the highly sensitive individuals. With a few children acutely subject to horse asthma such mixtures were used without noticing any symptoms of anaphylaxis.

A preliminary injection of antitoxin is no contraindication to the subsequent use of toxin-antitoxin; nor need there be any fear in giving a dose of antitoxin when necessary after a previous series of toxin-antitoxin injections.

The question of anaphylaxis and serum sensitization in human beings is a complicated one. While there are no external manifestations of anaphylactic shock or serum sickness in most individuals, it is more than probable that some manifestation of serum sensitization is present in human beings when a second injection of antitoxin is given. Such, for instance, may be the explanation of the much shorter protection after a second dose of antitoxin than after the first dose.

In a previous communication [4] we have shown that a first dose of 1,000 units of antitoxin protects a child for from twenty-one to twenty-four days, but a second dose of 1,000 units protects only for from seven to nine days. This may be explained by a more rapid breaking down of the antitoxin in the body as a result of proteolytic ferments that have been produced after the first injection of antitoxin. This accelerated destruction of the second dose of antitoxin serum is undoubtedly an internal manifestation of serum sensitization in human beings, who are, as a rule, much less prone to the more violent external manifestations of serum sensitization and anaphylactic shock than is the highly sensitive guinea-pig.

SUMMARY AND CONCLUSIONS

1. The immunity response to the same mixture of toxin-antitoxin varies greatly in different groups of children. A preliminary stimulation of the tissue cells in Schick-positive children caused by repeated exposure to infection with the diphtheria bacillus seems to enable the cells to give a better response to injections of toxin-antitoxin than in other children whose cells have not been previously stimulated by such exposure. This is the case even though these exposures have been slight and have not been apparent in the form of a perceptible increase of antitoxin in the circulating blood.

2. After a first series of toxin-antitoxin injections, the immunity response to the second series did not follow the same *inverse ratio* noted between original susceptibility of the children in a school and the percentage of successfully immunized children in the same school.

3. Three doses of toxin-antitoxin, each from 1 to 1.5 c.c., injected at intervals of one week, give much better immunity results than two doses of the same amount injected one week apart.

4. A longer interval between the injections of toxin-antitoxin has the advantage in allowing the local reaction to disappear more completely before the next injection of toxin-antitoxin is given. There may also be a better antitoxin response when the injections are given two weeks apart.

5. At least six months should be allowed to elapse after the injections of toxin-antitoxin before the Schick retest is made to determine accurately the development of an active immunity.

6. A second series of two or three injections of toxin-antitoxin should be given to those who have not become immune after the first series.

7. There are a few children who fail to develop immunity after toxin-antitoxin injections even when they are given several series of injections.

8. In the schools reported, from 70 to 93 per cent. of children were rendered immune after two series of toxin-antitoxin injections.

9. There is practically no danger from anaphylaxis, either in repeating the injections of toxin-antitoxin or in giving toxin-antitoxin after a preliminary injection of antitoxin.

ABSTRACT OF DISCUSSION

DR. FRANK C. NEFF, Kansas City, Mo.: I am sure that Dr. Zingher wishes to make this method of immunity by toxin-antitoxin available for every community, and if he does that he will have to make the technic as simple as possible. He did not touch on the details of the Schick reaction, but I know how he feels about it—that if we could do away with the Schick reaction in the first two years of life, it would simplify the procedure and make way for the campaign of toxin-antitoxin. I was interested in his observations on the results in institutions. During the last year I kept a record of positive reactions, and found that in private practice I get 66 per cent. of positive reactions, while in institution practice at the Gillis Orphan Home, we got only 40 per cent. That is a small observation, but it bears out that a contact immunity is developed by association with the disease. This is very interesting in prophylaxis of diphtheria. In other words, the children who have stayed in an institution for three months or more are more likely to have constant exposure to

4. Park, W. H., and Zingher, Abraham: Diphtheria Immunity, Natural, Active and Passive: Its Determination by Schick Test, Am. J. Pub. Health 6: 431-443 (May) 1916.

the diphtheria bacillus, and give fewer positive Schick reactions and better response to toxin-antitoxin immunization. I wish that Dr. Zingher would tell us something about the interpretation of the Schick reaction and also the way to tell when we may expect a reaction from the toxin-antitoxin. That is one of the most practical things about the Schick test. If we could simplify the terms used in the Schick test, it would be of value. I do not know whether the term protein reaction would be easier to understand than the term pseudo reaction.

DR. CHARLES GILMORE KERLEY, New York: Twenty thousand deaths from diphtheria is a startling figure in a disease about which we know so much. Something is wrong in our prophylaxis. Dr. Zingher says that 85 per cent. of children from 2 to 3 years of age are susceptible. I think it is far better to give those children toxin-antitoxin and immunize them than to put them through the process of the Schick test with which many physicians are not familiar. The better procedure will be to drop the Schick test for that age and immunize all children in the preschool age. In the older child who acquires a natural immunity, the Schick test should be applied. Dr. Zingher's statistics regarding the two types of children in the two classes of schools are most illuminating. It is probable that his conclusion that immunity is acquired through association with carriers is the right one. It is not infrequent that schools are found in which from 4 to 5 per cent. of the pupils have viable diphtheria bacilli in their throats and are not ill.

DR. C. A. EARLE, Des Plaines, Ill.: In an orphan asylum housing 1,200 children from 3 to 12, we have lost more cases from diphtheria in the last thirty years than from all other diseases and injuries combined. I think that Dr. Zingher is safe in saying that the mortality and incidence of the disease with our present methods will not be reduced. I started this work five years ago. We had lost seven out of eighty-five cases in six months preceding the beginning of this work. Since that time we have not lost a case of diphtheria. Three months ago there was the perfect setting for another epidemic of eighty-five or a hundred cases, but we had only five cases, all in children who had given positive Schick tests. I have given 3,600 doses of toxin-antitoxin to children without a single unpleasant result, other than an abscess of the arm in two cases. I do not see how anybody can read Theobald Smith's experiments on guinea-pigs without being convinced that there is something in toxin-antitoxin immunization, although all his experiments were done on guinea-pigs. The manifestations of diphtheria in the guinea-pig are in every way similar to that disease in human beings. In my experience, a positive Schick test is absolutely infallible as indicating susceptibility to diphtheria. Several times in this institution it has occurred that a child had received his Schick test, shown his susceptibility at the time, and then the parents or the court send for him. If he returns to our institution, singularly enough when a case of diphtheria occurs, it occurs in this child. The technic of the Schick test is so simple and its results are so accurate that none should be given the toxin-antitoxin mixture without the previous Schick test.

DR. HERBERT R. BROWN, Rochester, N. Y.: The toxin-antitoxin method of immunization against diphtheria has been the direct outgrowth of the work of von Behring and Theobald Smith, with whom I was associated some years ago. At that time we worked on guinea-pigs and immunized the females before conception had taken place, and also in the later course of the pregnancy, and we were able to produce an immunity in the offspring that lasted from three to four months. Dr. Zingher speaks of the heavy mortality in very early life, and it seems possible that we could reach the new-born infant by immunizing the pregnant mother and so save a great many lives. The establishment of the prenatal clinics offers opportunity for carrying out such work. I would like to ask Dr. Zingher for an opinion concerning the duration of the immunity produced by treatment with toxin-antitoxin mixtures. As regards the mixture, it is absolutely safe to use. At present I think we are using a slightly under neutralized mixture so that there will be at times slight desquamation of the skin but nothing else in the way of untoward symptoms. It will produce no fatality.

DR. WILLIAM A. MULHERIN, Augusta, Ga.: I apply the Schick test in all my cases before giving toxin-antitoxin. However, is not the value of the Schick test before giving toxin-antitoxin chiefly economic, rather than a medical necessity? With general practitioners uncertain about technic, and with doubtful interpretations of normal and pseudo-reactions, are we not justified, in many cases, in advising the administration of toxin-antitoxin without a Schick test? If I understand the principle on which the administration of toxin-antitoxin is based, the toxin, when injected into the tissues, causes antibodies to be formed in the body. A definite amount of antitoxin is combined with the toxin in order to neutralize the dangerous possibilities of the toxin. If the patient already possesses these antibodies (antitoxin) he is doubly protected, and toxin-antitoxin can do no harm. I realize that in rechecking, to determine whether a patient possesses immunity against diphtheria, the Schick test is necessary. I believe, however, that in some cases, and under ordinary circumstances, we are laying too much emphasis on the Schick test.

DR. ERNEST R. BROOKS, Cleveland: We have been using the Schick test and the toxin-antitoxin mixture in our schools for about a year, and our results correspond with those which Dr. Zingher obtained. We cannot yet give statistics, but our results agree with his.

DR. ABRAHAM ZINGHER, New York: Many of the points brought up in the discussion have repeatedly been emphasized in previous publications. Attention has frequently been drawn to the necessity of using the control test with heated toxin to facilitate the accurate interpretation of the Schick reaction in children more than 5 years of age and in adults. The advisability of omitting the preliminary Schick test and the giving of toxin-antitoxin to all children depends on different conditions. The age of the child is certainly an important factor. For practical reasons it would be well to omit the preliminary Schick test and to give three doses of toxin-antitoxin to all children between the ages of 6 months and 6 years. Children of school age, however, should receive the Schick test first, as in some schools as many as from 80 to 85 per cent. may be found to be naturally immune. But in rural communities the number of susceptible children in the schools is very high and in this group it may be found advisable to omit the preliminary Schick test. No child, however, should ever be pronounced immune to diphtheria after the injection of toxin-antitoxin and receive a certificate of protection until a Schick test has been made and a negative reaction obtained. These Schick tests could be given by the school physician to the children when they are admitted to school. We are now planning an extensive diphtheria prevention campaign in New York City among the children of preschool age. We will omit the Schick test and give the injections of toxin-antitoxin to all children between the ages of 6 months and 6 years. This work will be carried out in the baby health stations, in the day nurseries and in mothers' and babies' playgrounds in the public schools. The people of the city have been educated in the subject of diphtheria prevention through circulars which have been taken home from the schools by about 800,000 school children. A good deal of publicity has been given to it through the daily press. This is an important preliminary step in any comprehensive campaign of diphtheria prevention. The suggestion made to immunize the children in utero by injecting pregnant mothers is an interesting one. It will probably not be successful, as we have found that attempts to inject new-born children with toxin-antitoxin failed to produce an active immunity. The presence of antitoxin in the new-born interfered with the development of such an immunity. The active immunity produced by toxin-antitoxin has been found to continue for more than seven years. It is probably a more or less permanent immunity. The active stimulation of the tissues by toxin-antitoxin enables the cells to respond later with a further production of antitoxin as a result of repeated mild contact infection with the diphtheria bacillus, which is so important in producing the so-called "natural immunity."

THE POTENCY OF COMMERCIAL VITAMIN PREPARATIONS *

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There is no discovery in the fields of physiology and medicine which rests on a firmer experimental basis than that relating to the existence of several substances, still uncharacterized chemically, which the diet must supply if health and vitality are to be maintained. The most common term for this group of nutritive principles is vitamins, the individual substances being referred to as vitamin A, vitamin B and vitamin C. We have recently demonstrated the existence of a fourth one which plays a rôle in bone growth.[1] The first three of these have been conclusively shown to be etiologic factors in the so-called deficiency diseases, which term includes a type of ophthalmia of dietary origin, beriberi and scurvy, respectively.

It has been strongly urged by the group of investigators who have contributed the experimental data leading to the discovery of this remarkable class of substances that a well planned diet will afford an abundance of each of these dietary factors. No evidence whatsoever has been brought forward to show that an excessive amount of one or another of the vitamins is of value in the nutrition of either the sick or the well, but there is today a great wave of enthusiasm on the part of the public for information concerning them. There prevails in the minds of most people, however, a childlike confidence that these substances must have a medicinal value. As was to be expected, the graceless exploiters of human credulity have been quick to see the possibilities of financial gain through the sale of pills and extracts which purport to supply vitamins in concentrated form. The extensive advertising of such nostrums, and the reports of druggists as to the extent of the demand for these products, leave no room for doubt that there is a great demand for them and at fancy prices.

Owing to the rapid growth of the traffic in commercial vitamins, we thought it important to examine some of these preparations for their potency as sources of the most stable of these, the water-soluble B, or vitamin B, the antineuritic substance. Any one who is familiar with the chemical properties of the vitamins knows that there is little prospect of making concentrated preparations of any vitamin other than water-soluble B which contain any more active substance than is obtainable in certain foodstuffs that are easily procurable. It is, in fact, the water-soluble B or antineuritic substance that is most promoted commercially. The antiscorbutic substance, the vitamin C, is so unstable that it would seem to be impracticable to obtain it in concentrated form for use as a substitute for fresh vegetable foods, which are, in general, very rich in it. We have tested six of the products for vitamin B which have been more or less widely advertised, and present the results of our studies because of their interest to the medical profession.

An examination of the labels on the containers of the vitamin preparations which we have studied suggests at once that their promotion for therapeutic purposes represents a repetition of the "patent medicine" propaganda which has for so long been inflicted on the American public. Thus, the same list of general symptoms that were listed on the sarsaparillas, blood purifiers, kidney remedies, remedies for female weaknesses, etc., reappear as conditions for which the vitamin preparations are said to be specific remedies.

MASTIN'S YEAST VITAMON TABLETS

The directions for using Mastin's Yeast Vitamon Tablets, sixty of which retail for $1.10, are:

> Take two tablets with a swallow of water after each meal. To those who find it agreeable it is recommended that the tablets be taken with a glass of milk in place of a swallow of water whenever convenient. To derive most beneficial effects Mastin's Vitamon should be taken regularly and systematically for several weeks.

The tablets are said to contain all three vitamins "(Fat-soluble A, water-soluble B, and water-soluble C) highly concentrated with other such valuable health-building elements as Calcium Glycerophosphate, Nux Vomica and Peptonate of Iron."

It is further stated on the label that "this preparation contains vitamines together with other ingredients which should prove of value in helping to improve the appetite, aid digestion, correct constipation, clear the skin, increase energy, and, as a tonic, to assist in putting on weight in weakened, run down conditions due to malnutrition."

The results of the tests on this material are shown in Charts 1 and 2.

YEAST VITAMINE (HARRIS)

Yeast Vitamine (Harris), prepared by the Harris laboratories, Tuckahoe, N. Y., is marketed in tablet form. According to the label on the bottle it is:

> Prepared from fresh brewers' yeast (Saccharomyces cerevisiae). Water-soluble vitamine-B, highly concentrated. A natural food tonic and stimulant of cell activity.

It is stated on the bottle that:

> Each tablet contains 200 milligrams of standardized Vitamine fraction according to Osborne and Wakeman, Jour. of Biol. Chem., Dec., 1919, Chart III. It keeps indefinitely provided the bottle is corked when not in use. Dose: For adults, two tablets three times a day; children in proportion, as directed by a physician.

The preparation used by us was labeled "Control Number 978." The results of the tests on this material are shown in Charts 3 and 4.

"DOUBLE STRENGTH" YEAST AND IRON CONCENTRATE

The preparation "Double Strength" Yeast and Iron Concentrate is manufactured by the Hollander-Koshland Company, Incorporated, Manufacturing Pharmacists, Baltimore. The label on the bottle states the:

> Dose for adults two tablets after each meal, preferably with a glass of milk. If this is not convenient take with water.

The tests for the vitamin B content of these tablets are described in Chart 5.

* From the Department of Chemical Hygiene, School of Hygiene and Public Health, Johns Hopkins University.

* Since this paper was written, an article has appeared by Hess, Moore and Calvin (Experimental Studies with Proprietary Vitamin Products, J. A. M. A. 78:1441 [May 13] 1922) describing tests on guinea-pigs and pigeons of a number of commercial preparations for their antiscorbutic and antineuritic properties.

1. McCollum, E. V.; Simmonds, Nina, and Becker, J. Ernestine: Studies on Experimental Rickets, XXI, An Experimental Demonstration of the Existence of a Vitamin Which Promotes Calcium Deposition, Bull. Johns Hopkins Hosp., June, 1922.

IRVING'S PHOS-PHO VITAMINE

The label of Irving's Phos-Pho Vitamine reads:

60 Tablets—Price $1.00. . . . Is intended as a body cleansing, strength building, system regulating, nutritive tonic food. Distributed only by Irving Laboratory, Wheeling, W. V., U. S. A. Earle Chemical Co., Inc., Sole Owners.

It is also stated on the label that:

Irving's Compound Phos-Pho Vitanfine containing fat-soluble A and water-soluble B vitamines in combination with Glycerophosphates, Cascara, and other valuable ingredients. Directions: Take one or two tablets immediately after each meal with a swallow of water or milk. Recommended in the treatment of certain forms of Malnutrition, Simple Anemia, Boils, Carbuncles, Pimply Skin and Loss of Weight from run-down conditions.

The tests which we have made on this preparation are described in Chart 6.

ALPHA VITAMINE TABLETS

According to the label on the bottle, these tablets:

Contain the following vitamines: Fat-soluble A, water-soluble B, water-soluble C, and ingredients of Alpha Tablet No. 28. Indicated in the following diseases: Malnutrition, nervous deficiency, physical breakdown, brain fag, general debility. Dose: Two tablets, dissolved or swallowed with water or milk, three times a day.

The label on the carton in which the bottle is contained reads:

INDICATIONS—Useful in cases of Malnutrition, Constipation, Nerve Deficiency, Poor Health, Boils, Black Heads, Physical Breakdown, Disordered Metabolism, Scurvy and Pellagra.

The product is manufactured by Boericke & Tafel, Pharmaceutical Chemists, Philadelphia.

The results of the tests of this preparation are described in Chart 7.

"SUPER-VITAMIN" TABLETS

The circular which accompanies each box of "Super-Vitamin" tablets reads:

Directions for Taking "Super-Vitamin" Tablets

In the first place—remember—that in order to get the utmost in results, *"Super-Vitamin"* Tablets should be taken every day with consistent regularity, until the desired results are obtained. Follow the directions carefully. Remember *"Super-Vitamins"* are *"Super"* in every sense of the word. *Powerful.* Do *Not* take any more than directed, in the beginning.

For adults, begin by taking 1 Tablet directly after breakfast, and then 1 Tablet again directly after supper. Two a day is sufficient for the first 30 days. If you feel the awakening and energy being brought about too rapidly, take one tablet per day only for the first 15 days. Remember they are *"Super."*

Follow each Tablet with a glass of water. For growing children, One-Fourth Tablet once a day at supper time is plenty. Older children should take One-Half Tablet once a day at supper time.

The pleasant intestinal tonic built into *"Super-Vitamins"* makes assimilation pleasant and provides an excellent means of stimulating a healthy, gentle movement of the bowels. The action is quite positive. *"Super-Vitamins"* will loosen up the slime and accumulated bile and clean the system. Therefore a slight feeling of discomfort may manifest itself in the beginning, but this will only mean that these latent accumulations are being acted on for expulsion from the System. Don't let this worry you. The substantial tonic effect after a few days is wonderful.

Avoid the starchy foods and fats. Eat plenty of citrous fruits, such as Oranges, Grape-Fruit, etc. Do not over-eat. Eat at regular hours. Masticate the food well. Get regular rest. Take plenty of out-of-door exercise when possible.

In about 30 days you may increase the number of tablets to two at meal time. It is better to use the first bottle up—and then increase the quantity. Get your system accustomed to these energy builders first.

EVERYONE IS WILD OVER "SUPER-VITAMINS"

We predict that 25,000,000 people will be using "Super-Vitamins" in 6 months' times. They are a blessing to humanity.

GET THE GENUINE!

With *"Super-Vitamin"* Trade-Mark, shown below, in every package.

"SUPER" VITAMINS TRADE MARK

"Super-Vitamins" are more than Vitamins. They are Vitamins-Plus, and then some. You will realize this before you have taken them 10 days.

Sold only by
THE JAMES-VICTOR-EVANS COMPANY
Steubenville, Ohio, U. S. A.

The results of our tests on this material are described in Chart 8.

NATURE OF CLAIMS

The claims set forth on the labels of the medicinal values of these preparations are extravagant and misleading. They do not contain the vitamin B in concentrated form as they are represented to do. The marketing of these preparations represents an attempt, and unfortunately a successful one, to substitute a commercial vitamin propaganda for the nefarious "patent medicine" business which the American Medical Association has done, during the last twenty years, so much to suppress for the protection of the public.

The drug store is not the place to secure vitamins. Laboratory research during recent years has revealed in detail the specific dietary properties of all our more important natural foodstuffs. Many hundreds of careful tests have made clear what combinations of food substances are likely to promote good nutrition. On the basis of the abundant data available we have for several years been urging the adoption of a system of diet by the American people which promotes health far better than our white bread, muscle meat, potato and sugar type of diet can ever do.

During the last century we have developed industrially to a degree hitherto unapproached, and the populations of Europe and America have greatly increased and have tended to become more and more urban. This has necessitated changes in agriculture which have become possible through the invention of modern farming implements, and the adoption of new methods of food distribution. With these changes in living habits have come changes in our diet. It has become essentially one consisting of highly milled cereal products, muscle meats, potatoes and sugar. This is a failure in animal experimentation and is proving a failure in human experience. Evidence that this is true is abundantly supplied in the percentage of underweight children in our schools, and in the prevalence of rickets and other skeletal defects, small jaws and teeth which are irregular, poorly developed, and which decay early.

Milk and leafy vegetables are of outstanding importance in that they are so constituted as to make good

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the deficiencies of the white bread, meat, potato and sugar type of diet. In order to differentiate them as sharply from other foods as their importance deserves, we have during the last few years designated them the protective foods.

Chart 1.—Period 1, basal diet; Period 2, basal diet plus Mastin's Yeast Vitamon Tablets equivalent to the dosage recommended for human consumption; Period 3, basal diet plus 4 per cent. of wheat germ as a source of water-soluble B.

The system of diet which we recommend is in no respect radical. It includes borrowing the best features of several types of diets employed by man in several parts of the world. The consumption of liberal amounts of milk and its products is the main feature of the diets of pastoral peoples, whose nutrition leaves little to be desired. Primitive peoples are accustomed to the consumption of considerable amounts of raw foods.

DIETARY REFORMS

Reduced to its simplest terms, the most important dietary reforms which we can introduce are:

1. Salads should be eaten twice each day. This will insure the regular consumption of some raw fruit, raw cabbage, raw celery, tomatoes, lettuce, etc., since these enter so frequently

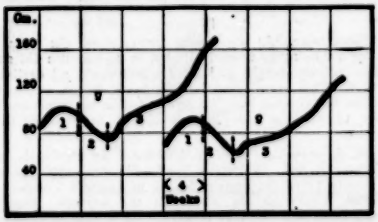

Chart 2.—Period 1, basal diet; Period 2, basal diet plus Mastin's Yeast Vitamon Tablets equivalent to twenty times the dosage recommended for human consumption; Period 3, basal diet plus 4 per cent. of wheat germ as a source of water-soluble B.

into the composition of salads. The consumption of such foods provides an abundance of the antiscorbutic substance in which our diet of cooked foods is likely to be lacking.

2. Each day a liberal helping should be taken of some food which we would class as pot-herbs or greens. This insures the regular consumption of some leafy vegetable. These, as has been pointed out, possess dietary properties which make them unique among the vegetable foods.[2] This practice will likewise go far toward correcting constipation, which is the bane of the existence of a large portion of our population.

3. Each day a quart of milk or its equivalent in the form of manufactured dairy products should be taken.

2. McCollum, E. V.: The Newer Knowledge of Nutrition, Ed. 2, New York, the Macmillan Company, 1922.

If one lives up to these rules, which will mean that the diet will be so planned as to include a sufficient amount of the protective foods, the remainder of the diet may be selected entirely on the basis of its appeal to the sense of taste. One may be assured that the food supply as a whole will be such as to promote health. When a diet such as this is adhered to there will be a great abundance of vitamins in each day's food supply.

METHOD OF CONDUCTING THE TEST FOR THE VITAMIN B (WATER-SOLUBLE B) IN THE PREPARATIONS DESCRIBED

Young rats were confined to a diet of purified casein, 18 per cent.; agar-agar, 2 per cent.; salt mixture (185), 3.7 per cent.; dextrin, 71.3 per cent., and butter fat, 5 per cent. This is the basal ration to which reference is made in the legends to the charts. On this diet the animals grow somewhat during the first two or three weeks; then the weight becomes stationary or declines. They grow feeble and irritable, and within two or three weeks they, as a rule, develop symptoms of polyneuritis or experimental beriberi. They sometimes die without manifesting the symptoms characteristic of this disease.

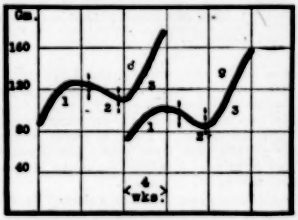

Chart 3.—Period 1, basal diet; Period 2, basal diet plus Yeast Vitamine Harris Tablets equivalent to three times the dosage recommended for adult consumption; Period 3, basal diet plus 4 per cent. of wheat germ as a source of water-soluble B.

Since the recovery of the rats is uncertain if they are brought to the verge of collapse, we found it desirable to administer the remedial measures before the animals were seriously depleted. This was not invariably done, but the exceptions are noted in the legends to the charts. When, employing the foregoing diet, a source of water-soluble B is supplied to rats which are rapidly declining in weight and strength, they respond with complete recovery, and growth begins after a few days. Wheat germ is an excellent source of this vitamin, and when administered to the extent of 4 per cent. of the food mixture to animals which are about to

Chart 4.—Period 1, basal diet; Period 2, basal diet plus Yeast Vitamine Harris Tablets equivalent to twenty times the dosage recommended for human consumption.

decline as the result of specific starvation, they make a very quick response with growth. Typical curves showing this are presented in Chart 9.

In calculating the dosage of vitamin tablets in these experiments we assumed that the dosage recommended by the manufacturer applied to a human subject of 70 kg. of body weight. The dosage for the rats was calculated on a corresponding weight basis.

RESULTS OF TESTS

Chart 1.—*Mastin's Yeast Vitamon Tablets.* The records in this chart show the failure of young rats to grow in Period 1 when confined to the basal diet, which was complete except that it lacked the vitamin B, or water-soluble B. This is the so-called antineuritic substance, a lack of which causes beriberi. In Period 2, a quantity of Mastin's Yeast Vitamon, equivalent on a basis of body weight to the dosage recommended on the label for human use, was added to the basal diet. There was not only no improvement in the condition of the animals, but they gradually grew weaker during the four weeks covered by this period. In Period 3 the Mastin's

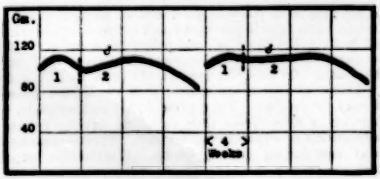

Chart 5.—Period 1, basal diet; Period 2, basal diet plus Yeast and Iron Concentrate tablets equivalent to twenty times the dosage recommended for human consumption.

Yeast Vitamon tablets were omitted, and 4 per cent. of wheat germ was introduced instead. Wheat germ is known to be very rich in water-soluble B. As soon as the animals received this source of the B factor, their response was immediate and spectacular. Their strength returned, and they resumed growth at a rapid rate. The Yeast Vitamon tablets did not furnish an appreciable amount of the vitamin, which they are advertised to contain.

Chart 2.—*Mastin's Yeast Vitamon Tablets.* In the experiments described in this chart, the conditions maintained were identical with those described in Chart 1, except that in Period 2 the dosage of Mastin's Yeast Vitamon was greatly increased. In Period 1 the animals received the basal diet without supplements. In Period 2, Mastin's Yeast Vitamon

Chart 6.—Period 1, basal diet; Period 2, basal diet plus Irving's Phos-Pho Vitamine Tablets equivalent to twenty times the dosage recommended for human consumption; Period 3, basal diet plus 4 per cent. of wheat germ as a source of water-soluble B.

was introduced into the food mixture in amount equivalent to twenty times the dosage recommended for human use. The animals failed to respond with improvement of health in any instance. In Period 3, 4 per cent. of wheat germ was introduced, and the Vitamon tablets were omitted. As soon as this change was made, there was a rapid improvement in the case of both animals. Mastin's Yeast Vitamon does not contain more than traces of water-soluble B, and is very inferior to most of our ordinary foods in its content of this substance.

The rats, after being confined to the diet of Period 2 for twenty-one days, were in a very feeble condition, and exhibited symptoms of incipient polyneuritis. They could not have lived more than a day or two, yet a liberal administration of water-soluble B in the small amount of wheat germ which was then given led to rapid recovery and resumption of growth.

Chart 3.—*Yeast Vitamine (Harris).* In Period 1 the animals were fed the basal diet. In Period 2, which covered three weeks, the diet was supplemented with three times the dosage of Yeast Vitamine Harris recommended on the label for human use for the adult. Notwithstanding this liberal administration of the Yeast Vitamine Harris tablets, the animals continued to decline in weight and to grow more feeble. Obviously, the tablets contain at most but a trace of the vitamin for which they are recommended. In Period 3 the Yeast Vitamine Harris was omitted, and 4 per cent. of wheat germ was added to the diet. In all cases there was immediate improvement in the condition of the animals, and growth was resumed at a rapid rate.

At the end of Period 2, the rats were frail and walked with a tottering gait. It was believed that they would have either developed experimental beriberi or have died within forty-eight hours had a source of water-soluble B not been given them at that time.

Chart 4.—*Yeast Vitamine (Harris).* In Period 1, the animals were fed the basal diet. In Period 2, the diet was supplemented with twenty times the human dosage of Yeast Vitamin Harris tablets. There was a fair response with growth, but not so striking as in our experience is seen when under such experimental conditions 4 per cent. of wheat germ is added (compare Chart 9).

Chart 5.—*"Double Strength" Yeast and Iron Concentrate.* In Period 1, the rats were restricted to the basal diet. In Period 2, this diet was supplemented with twenty times the recommended dosage of the "Double Strength" Yeast and

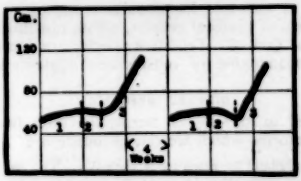

Chart 7.—Period 1, basal diet; Period 2, basal diet plus Alpha Vitamine Tablets equivalent to twenty times the dosage recommended for human consumption; Period 3, basal diet plus 4 per cent. of wheat germ as a source of water-soluble B.

Iron Concentrate. As the weight curves show, the animals were for a time saved from death, but in no instance did any increase in body weight, and after a few weeks all declined and died. This preparation, as purchased by us, is nearly free from the vitamin B. The term yeast in its name would suggest to most persons that it should be rich in this substance.

Chart 6.—*Irving's Phos-Pho Vitamine.* In Period 1, the basal diet was fed. In Period 2, this diet was supplemented with twenty times the human dosage of Irving's Compound Phos-Pho Vitamine. In all cases the animals steadily declined in weight and were in a very feeble condition when, in Period 3, 4 per cent. of wheat germ was substituted for the vitamin preparation. As soon as this change was made in the character of the food, the rats began to improve in health, and growth was resumed in all cases.

One of the rats whose curve is shown in the chart was extremely feeble at the end of Period 2. Six days later it was still very sick, but improved soon afterward, and grew slowly during the next four weeks. It had sufficiently recovered at this time so that growth took place at a rapid rate thereafter.

Chart 7.—*Alpha Vitamine Tablets.* In Period 1, the basal diet was fed. In Period 2, the diet was supplemented with twenty times the amount of Alpha Vitamine Tablets recommended for human use. In no case were the animals benefited by this material. After two weeks of the Alpha Vitamine treatment, their condition was distinctly worse than when the preparation was first fed. They were then (Period 3) given 4 per cent. of wheat germ instead of the vitamin preparation. All but one animal grew at a rapid rate after this change was

made. It will be noted from the chart that one of the rats did not grow until the second week after the wheat germ was supplied. This was due to the fact that it had developed beriberi and had to be fed a water extract of wheat germ with a medicine dropper. Obviously, the preparation is worthless as a source of one of the vitamins for which it is so highly recommended.

CHART 8.—*"Super-Vitamin" Tablets.*—In Period 1, the basal diet was fed. In Period 2, "Super-Vitamin" tablets equivalent to twenty times the dosage recommended for human use (on the basis of six tablets a day) supplemented the basal diet. The rats continued to decline without exception after

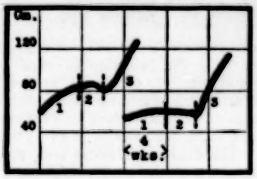

Chart 8.—Period 1, basal diet; Period 2, basal diet plus "Super-Vitamin Tablets" equivalent to twenty times the dosage recommended for human consumption; Period 3, basal diet plus 4 per cent. of wheat germ as a source of water-soluble B.

the vitamin preparation was administered. After three weeks, Period 3 was begun, in which 4 per cent. of wheat germ replaced the "Super-Vitamin" tablets. All the animals which were included in the test grew very rapidly as soon as the vitamin for which they were starving was made available. "Super-Vitamin" tablets do not contain demonstrable amounts of the antineuritic vitamin or water-soluble B.

CHART 9.—*Basal diet.* In Period 1, the animals were given the basal diet. After the initial period of growth, their weight became stationary or nearly so for two weeks. On the addition of water-soluble B to their diet in the form of 4 per cent. of wheat germ, they resumed growth at once.

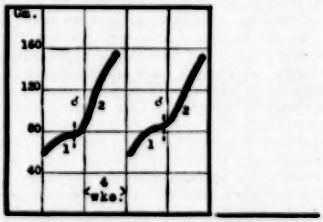

Chart 9.—Period 1, basal diet; Period 2, 4 per cent. of wheat germ added to the ration.

In other experiments we have demonstrated that young rats can be given as much as 80 per cent. of wheat germ (fat-free) properly supplemented with respect to calcium and fat-soluble A, without interfering in any way with their rapid growth in experiments covering several weeks. This shows that twenty times the dosage of water-soluble B that just suffices to induce normal growth does not noticeably disturb the health of young rats in such intervals of time as are covered by our tests.

Japan's Death Rate.—According to the latest statistics, the death rate in Japan has increased, while the birth rate has diminished, the death rate showing 26.8 per thousand, and the birth rate 32.2 per thousand.

MYOCARDITIS AND ITS MANAGEMENT *

WILLIAM A. JENKINS, M.D.
LOUISVILLE, KY.

There is a broadcast and growing tendency on the part of medical men (teachers, writers and practitioners) to use the term myocarditis too loosely and too frequently. As a result, much confusion has arisen, and will continue to arise, until an understanding is reached concerning this matter, or, until some uniform classification of myocardial conditions is adopted.

At the present time the medical profession is more or less divided against itself on this subject. One half of the physicians are not quite sure that they comprehend fully the conception which exists in the minds of the other half when they talk of myocarditis. Many men tell us that they make the diagnosis of myocarditis quite frequently, as their case records show. Others, equally active, prominent and proficient, say that, on the contrary, the cases are few and uncommon. What is the trouble? It is quite evident; we are not all talking about the same thing. The term myocarditis is being applied by some men to certain transient, functional states, to neurotic conditions, and to various toxemias.

The basis for distinction, as well as the point of interest, in this numerically large group of cases is that, in the great majority of instances, they clear up completely. They are temporary or functional in character. They have no pathologic condition behind them. Given the factors of time, nature, and the aid of the physician, the condition disappears altogether. The heart returns to a normal state. A condition of restitutio ad integrum obtains.

CLASSIFICATION

For the accurate classification of the subject under consideration, pathology is our only rational basis. I should define myocarditis as "a condition in which pathologic change has taken place in the substance of the heart muscle itself." The term should be held in reserve and applied to such cases and to them only. With this common understanding we could readily divide myocarditis into the acute and the chronic types. The acute type is strictly inflammatory. A virulent acute infection, may give rise to a widespread acute inflammatory process in the myocardium. A localized accumulation of leukocytes occurs; edema is present; fibrinous coagulation takes place; granular or hyaline changes are found, and the process is accompanied oftentimes by softening and necrosis (localized abscess formation).

The chronic type, from the pathologic point of view, is very closely allied to the type described above. In fact, it is almost indistinguishable from it in the very early stages, for there is, in the beginning, the same stage of local congestion, leukocytic infiltration, etc. The analogy ends here, however. Softening and necrosis do not occur in the chronic forms. Instead, there is a low-grade, slow, insidious change taking place which tends, clinically, toward one of the well recognized types of degeneration; or a process of substitutive fibrosis appears which results ultimately in hard, shrunken tissue.

DIAGNOSIS

The diagnosis of myocarditis is beset with difficulties. As a rule, it is not possible (except in the rarest

* Read before the Section on Practice of Medicine at the Seventy-Third Annual Session of the American Medical Association, St. Louis, May, 1922.

instances) to make the diagnosis off hand, or, even after one or two hasty examinations. A closer study of our patients and their symptoms is required, a more thorough analysis of the cause, meaning, and progress of the symptoms. Years of clinical experience, with the deductions and knowledge which accrue therefrom, enriched by the modern method of postmortem study, are all necessary adjuncts to diagnosis.

The greatest difficulty is encountered in diagnosing the acute types. Most commonly the clinical picture of acute myocarditis hides under, or merges itself with, the primary disease, in a way that is quite baffling. However, at its onset there is likely to be a sudden increase in the degree of the illness of the patient; also a marked increase or accentuation of all the symptoms, and, in addition, signs which point overwhelmingly to a failing heart, for example, a sense of tightness or constriction, and even pain, in the chest; labored or difficult breathing, a weak, rapid and irregular pulse, of low tension; distant and toneless heart sounds; relaxed heart muscle and dilated chambers; systemic distress; cyanosis and even death. In some instances, diagnosis may be a matter of approximation, or a shrewd guess. (Yet we frequently see cases with overwhelming evidences of cardiac weakness, accompanied by an infectious endocarditis and often a definite blood stream infection, in which we have made a diagnosis of acute myocarditis which has been verified by postmortem findings.) On the other hand, in the chronic type, into which class the greatest number of our cases fall, the diagnosis may be made, in almost every instance, by the well trained, skilful physician.

In the chronic type, the syndrome has a very wide range of variation. Much will depend on the extent of the involvement, and the location of the pathologic condition of the heart muscle.

The essential factor that is common to all types is the presence of signs of cardiac failure which tend to become permanent, and which are accompanied by exhaustion of the cardiac reserve force. Our attention is attracted by such symptoms as shortness of breath, tiring very easily, a sense of tightness or constriction, even pain in the chest, weakness, attacks of rapid beating of the heart, skipping of heart beats. At first, we are at a loss to understand these symptoms. We take into consideration the age, development, occupation, amount of exercise taken, personal habits, etc., of the particular patient; but we cannot account for them on this basis. Then, we begin an intensive study of the particular case. We study the heart at rest and at work. We make use of the well known tests, such as shadow runs, hopping and climbing stairs. We make accurate observations of the blood pressure, of the rate and rhythm of the heart before starting exercise, immediately after its completion, and at five minute intervals thereafter, for three or four observations. We tabulate and study our results. We compare them with what our experience has taught us to consider a rough normal. At the start, these symptoms are brought out only after exertion (moderate or severe). As time goes on, it takes less to elicit these symptoms and they last longer (the cardiac reserve force is lessening). Finally, the symptoms present themselves at intervals, even when the patient is at rest.

The picture described above is the corner stone, the essential feature of our diagnosis of chronic myocarditis. It may have accompanying it, superimposed upon it, and, in some instances, almost overshadowing it, certain other phenomena. For example, involvement of the coronary arteries may present marked symptoms of angina pectoris. If the main stem of the conduction bundle is involved, there are likely to be definite and almost diagnostic rhythmic phenomena. Chronic pericarditis, as an accompaniment, would add its syndrome to the picture. Chronic endocarditis, with its distinctive and well known clinical picture (hypertrophy and dilatation, valvular disease, dropsy, passive congestion of the viscera, and changes in organs remote from the heart, etc.) may overshadow, or temporarily obscure, the underlying condition.

These remarks on diagnosis may be summarized thus:

1. It is not so much the number or character of the symptoms as it is the behavior of these symptoms, from the standpoint of time and progression, that enables us to draw valuable diagnostic conclusions.

2. Evidences of cardiac failure and the reduction of cardiac reserve force are present in every true case of myocarditis. The degree of failure and rapidity of its progress will vary with the case.

3. Careful and repeated observations must be made at intervals, and the sum total of these observations must cover a considerable period of time.

4. We must employ the method of diagnosis by exclusion, thus getting rid of temporary disturbances, such as neuroses.

5. The syndrome must be constantly present, easily brought out by exercise, and must show a tendency toward gradual progression.

TREATMENT

The outlook, from the standpoint of treatment, of myocardial conditions is far from brilliant. In the acute form, in which diagnosis is difficult or conjectural, we necessarily turn our attention to the accompanying process, namely, the overwhelming infection, or general septic condition, meeting the prominent, or outstanding, conditions as best we may.

In the chronic form, with its low-grade and constantly progressive tendency to degenerative, or fibrotic, change, we at least have an abundance of time at our disposal in which to formulate, mature and apply our therapeutic schedule. Our results, however, are not particularly flattering. A consideration of the modus operandi of the pathology in these cases teaches us that the damage is already beyond repair when the case comes to the knowledge of the physician. At this time, it is entirely a question of conservation or management. It is best, at the outset, to acknowledge frankly that we have no specifics. We must work along general lines.

Our first duty is to ascertain, within as narrow limits as possible, the exact status of the heart when we take charge of the case; to determine the extent of the damage to the heart and the condition of the cardiac reserve force. Repeated detailed observations of the heart over long periods of time, the tabulation of our results for purposes of comparison and the application of the various forms of the work test furnish us with an approximate answer to these questions, as shown, in detail, elsewhere in this paper.

Following this determination, we must discover the condition and functional capacity of the other vital organs of the body. Are the lungs normal, or are they impaired by disease? Are the kidneys competent, or is there an advanced nephritis? What of the condition of the gastro-intestinal tract so far as digestion, absorption, and elimination are concerned? The patient's metab-

olism should be determined, including the condition of the liver and the blood. We should discover whether or not the arteries are atheromatous. If we find trouble anywhere we should remove it. If this is not possible, then we should do our best to ameliorate it. Having first attended to these things, we are in a position to map out a schedule, a daily routine, for our patient. This schedule must be ordered in strict accordance with a summation of the factors ascertained under the first and second investigations. To state the matter very simply and bluntly, having gotten the patient in the best possible condition, we must reduce his work, mental and physical, to the point at which it coincides with his capacity. Thus we minimize cardiac strain, reduce the work which the crippled heart has to do, and at the same time, we prolong and render more comfortable the life span of our patient. The foregoing is, by all odds, the most important and valuable factor in the management of chronic myocarditis.

Second, and next in importance, comes the adoption of such measures as will tend to combat, or, at least, retard, the degenerative changes. All of the procedures mentioned under number one will have at least an indirect use here. All of the factors which go to make up the patient's daily round of life must be carefully supervised and directed by the physician. Violent exercise, overfeeding, excesses in alcohol, tobacco and venery are harmful. Rest, particularly in people who do physical work, is a useful measure. It may be necessary to reduce the amount of the work done or even to change the occupation. In the type of case in which the occupation requires the expenditure of mental, rather than physical, energy, moderate and supervised exercises (medical gymnastics) may be employed, such as tension and resistance movements and graduated hill climbing (the Oertel system). Some practitioners use the Schott system of medicated baths, with apparent benefit. If we are fairly certain that the degenerative process is due to some definite cause, the cause should be treated; for example, if the condition is due to syphilis, the proper use should be made of antisyphilitic treatment. In the presence of anemia and a poor physical condition, iron in moderate doses is a useful remedy. I believe that strychnin, the nitrate or sulphate, 1/30 grain (0.002 gm.), after meals, used for considerable periods of time, with rests between, has a place in steadying and strengthening the heart. If the kidneys are not functioning properly, theobromin sodiosalicylate, 10 grains (0.6 gm.), in water, at four hour intervals, may be used. High blood pressure, with thickened tortuous arteries, would suggest a trial of nitroglycerin and the nitrites. In the application of the various therapeutic measures which come under this heading, we are oftentimes alleviating conditions remote from the heart, or, we are acting on structures which are capable, at least temporarily, of relieving the heart of some of its load.

Third, we must consider the judicious use of remedies which will stimulate, or act directly upon, the heart muscle itself. In this connection, as a matter of course, digitalis is the first drug that comes to mind, since it is very justly known as the king of cardiac tonics. If myocardial change has arisen from an extension of, and is, in fact, part and parcel of, an old, chronic and well marked endocarditis, which is accompanied by valvular leakage, hypertrophy, dilatation and dropsy, digitalis may give brilliant results, at least in the earlier stages of the case. However, as we all know, even in this type of case, there comes a time, late in the clinical history of the disorder, when even digitalis is unable to revive the failing heart. This occurs in the exceptional case. In, perhaps, most of our cases, and this is especially true in the type of case that proves most desperate, intractable, and hardest to diagnose and treat, endocarditis is not present at all. There is neither hypertrophy and dilatation nor dropsy. In this relatively large class, digitalis is disappointing, and is very limited, indeed, in its range of usefulness. Here, large doses of this drug are actually harmful. In these instances digitalis, if used at all, should be used only in small doses over moderate periods of time and not as a routine measure. If we believe that the drug is benefiting our patient to a certain extent, we should make occasional and appropriate use of it, according to the indications.

Strophanthus is advocated by many clinicians for its supposed influence on the heart muscle. This drug does not produce vasoconstriction of the arterioles; hence it does not raise the blood pressure. It is also asserted that it does not produce nausea. I believe, however, that this statement is questionable. If the patient is in desperate straits, if the circulatory embarrassment is extreme, if digitalis and the other measures that are being employed are not helping much, temporary, but distinct, benefit may be obtained by using strophanthin, 1/100 grain (0.0006 gm.) by hypodermic injection, intravenously, at two or three day intervals. The patient should be watched closely and not more than three or, at the outside, four doses should be given. A word of caution is necessary regarding the use of strophanthus. It should never be used at the same time as digitalis, for death may be the result. A minimum period of at least a week should elapse after the last dose of digitalis is taken before the administration of strophantus is begun.

Cane sugar, 2, 4 or 6 ounces (57, 113 or 170 gm.) a day, is supposed to have a nourishing effect on the weakened heart muscle. It is well thought of in certain quarters, especially by English writers and clinicians.

The whole subject of treatment may be condensed thus:

1. There are no specifics.
2. Drugs are secondary in importance to the other measures mentioned in this paper.
3. Much will depend on the physician managing the case, upon his skill and ability to collect, summarize and properly evaluate all of the various and intricate factors entering into the case.

If any benefit is obtained, it will be secured by working along these general lines: (*a*) All measures that will tend to make easy the work which the crippled heart has to do should be adopted. (*b*) Appropriate use should be made of all measures that will tend to combat, or retard, the progress of the degenerative changes. (*c*) The judicious use of remedies which will stimulate or act directly upon the cardiac muscle itself is demanded.

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ABSTRACT OF DISCUSSION

DR. W. E. SIMMONDS, Chicago: I have been using strophanthus and I find that, as a rule, the dose given in books is too large. I use one fourth of the regular dose. I generally give a digitalis preparation, and then, when the effect begins to be lost or becomes ineffectual, I continue with stro-

phanthus. I use the ampule containing 1/100 grain of strophanthin, or the tincture.

DR. WILLIAM A. JENKINS, Louisville: I am heartily in favor of instrumental means of interrogating the heart and freely utilize such of them as are available to me. The electrocardiograph is destined to become the most valuable of the group. Like all other laboratory procedures, however, its value is confirmatory rather than conclusive. The man who is willing to commit himself on the question of prognosis from cardiographic readings alone is exceedingly injudicious and indiscreet and he will soon come to grief. Single or isolated readings are not dependable. Readings must be had under varying circumstances of rest and exercise, and they must be studied in connection with the carefully gathered clinical data in the given case if they are to be of real value. Again, at this date, information is furnished by the electrocardiograph to only an exceedingly small number of physicians, whereas, the clinical measures which I have emphasized in my paper, in addition to being accurate and dependable, are available to every practitioner in every locality.

THE RELATION BETWEEN MIGRAINE AND EPILEPSY

WITH ESPECIAL REFERENCE TO THE CARDIOVASCULAR DISTURBANCES IN MIGRAINE *

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The occurrence of migraine and of epileptiform convulsions in the same patient has been noted by many observers, Flatau,[1] in his exhaustive monograph on migraine, stating that among 500 personal observations these conditions appeared in the same patient in thirty-six instances, approximately in the proportion of 1 to 14. My own interest in this subject was first aroused by two patients who came under my observation several years ago. In these cases, the epileptiform seizures occurred after the attacks of migraine had persisted for many years, the epileptiform attacks being either coincident with or replacing an attack of migraine. The point of especial significance in these patients, according to my conception, was the progressive development of well-marked cardiovascular changes. The purpose of this presentation is to direct attention to the etiologic significance of this factor in cases of this type.

REPORT OF CASES

CASE 1.—A man, aged 54, consulted me in May, 1908, because of a temporary aphasia which had developed at the onset of an attack of migraine; at the same time he experienced a numbness in the right arm and a sense of weakness. These passed off in a few hours, but the attack of migraine which followed was severe. The arteries were comparatively soft, the systolic blood pressure, 140. The urine showed no albumin or casts, and, with the exception of a chronic infective arthritis, the patient's general physical examination revealed nothing abnormal.

Because of the arthritis, I had the opportunity of following this patient closely until he died, March 30, 1918. During this period he had had several attacks of severe migraine, some of which, like the one described above, were accompanied by aphasia, with numbness and weakness in the right arm.

In 1914, the urine began to show a trace of albumin and a few casts, and the total quantity of urine passed at night was increased. At the same time the blood pressure was elevated, so that an average of various readings taken during 1914 showed a systolic blood pressure of 152, diastolic 90; an average of the blood pressure readings during 1915 showed systolic pressure, 164; diastolic 98; during 1917, the average systolic pressure was 185, diastolic 105; there were signs of hypertrophy of the heart, and the arteries showed increasing sclerosis.

In July, 1915, the patient had a severe attack of migraine which, like the others described above, was accompanied by aphasia and numbness of the right arm. This attack persisted for eight hours, at the end of which he had a severe generalized convulsion followed by a period of unconsciousness which lasted for six hours and was followed by paralysis of the right side of the face, right arm and right leg, with complete motor aphasia. Within forty-eight hours the patient had regained completely the use of his right arm and right leg, and the power of speech returned. He had four more of these attacks before his death in 1918, the last one being followed by a period of unconsciousness from which he did not rally.

Necropsy disclosed a general arteriosclerosis with advanced arteriosclerosis of the cerebral vessels, but no evidence of hemorrhage; left ventricular hypertrophy of the heart, and a small, contracted, arteriosclerotic kidney.

CASE 2.—A woman, unmarried, aged 36, was under my observation for six years. Her father died at the age of 50 from an attack of angina pectoris; her mother died at the age of 73 from carcinoma of the uterus. She had four brothers and one sister living and well, none of whom had had attacks of migraine. Until five years before she first consulted me the patient had always been well, except that she had had frequent attacks of migraine of the ophthalmic type. She usually had a definite warning of the onset of the migraine from the appearance of flashes of light in front of the eyes and at times a definite fortification spectrum in the right eye. The attacks of migraine were sometimes so severe that the patient was completely incapacitated for several days.

Five years ago the attacks of migraine were replaced by epileptiform convulsions. These epileptiform attacks came on without any definite aura, and consisted sometimes of but one convulsion, at other times of several convulsions within a period of twenty-four hours. The intervals between these attacks varied from one to four months. The patient always remained in a semiconscious, stuporous condition for several hours, and afterwards had no knowledge of what had occurred, thinking that she had had an ordinary attack of migraine. Within the last two years there has been a gradual mental deterioration. During the last six years the patient has had a gradually developing, well-marked arteriosclerosis, the systolic blood pressure varying between 160 and 200, the diastolic between 100 and 110. In 1920 she had two attacks of paroxysmal tachycardia, each lasting between two and three hours. The urine always showed a trace of albumin and some casts.

In April, 1921, a complete diagnostic study of the patient was made. The general physical examination revealed nothing of importance beyond a well-marked arteriosclerosis with moderate cardiac hypertrophy. There was a moderate grade of anemia, 3,169,000 red blood corpuscles, 60 per cent. hemoglobin, and 7,800 leukocytes. Blood chemistry examination revealed: blood urea, 8.6 mg.; blood sugar, 106 mg.; blood chlorids, 586 mg. per hundred cubic centimeters. The excretion of phenolsulphonephthalein for two hours was 90 per cent. A roentgenologic examination of the gastrointestinal tract revealed a marked gastroptosis and coloptosis. No focus of infection in the teeth or sinuses was revealed by the roentgen ray. The patient died a few days ago from a carcinoma of the splenic flexure of the colon. No necropsy was obtained.

COMMENT

In each of these cases the appearance of the epileptiform attacks was coincident with progressive cardiovascular changes which were so marked as to suggest strongly a direct etiologic significance.

In a study of the literature pertaining to the association of migraine with "epilepsy," the foregoing point has therefore been especially borne in mind. No

* From the Cleveland Clinic.
* Read before the Section on Practice of Medicine at the Seventy-Third Annual Session of the American Medical Association, St. Louis, May, 1922.

1. Flatau, E.: Die Migräne, 1912 (includes a very extensive bibliography).

attempt has been made to give an exhaustive discussion of the literature as a whole, and I shall present only a brief summary of the outstanding features of the reported cases as presented by various observers.

Cases of migraine associated with convulsions fall into three groups, according to the sequence of the attacks.

The first group comprises those cases in which the migraine appears first, the epileptiform attacks appearing later, often after many years. The cases described above belong to this group. In these patients the convulsions may accompany an attack of migraine or may replace it. It is significant to note that in most of the reported cases which belong in this group the epileptiform attacks first appeared after the patient had reached the age of 40, an age when cardiovascular changes are more likely to be present than in earlier years. In women, these attacks of epilepsy usually occur at the menopause, when we know, as stated by Riesman,[2] that hypertension is likely to develop.

The second group consists of cases in which epilepsy appears first, attacks of migraine making their appearance later. Two typical cases are described by Kovalevsky and Féré. Kovalevsky's case was that of a 16 year old girl, whose father had suffered from syphilis and whose mother had suffered from headaches. From her third to her fifth year she had had epileptic attacks, but since her twelfth year she had suffered from migraine alone. Féré describes the case of a woman, aged 41, who in her eighth year had suffered from right sided convulsions. For eight or ten years she had attacks of numbness in the right hand, sometimes in the right leg, accompanied by a twitching of the mouth. These attacks occurred early in the morning and lasted for an hour. These were the only symptoms of which she complained for a year, but for the last two years she had suffered from ophthalmic migraine, with entoptic scotoma and hemianopia.

The third group comprises those cases in which the migraine and epileptiform attacks alternate. Gowers[3] has reported two interesting cases of this type, one of which he thus describes:

> A physician, aged 38, whose family history included gout and migraine, but neither epilepsy nor insanity, since the age of 15 had suffered from characteristic migraine, the headache being preceded by visual spectra. At the age of 7 he had had some brief attacks of micropsia in which objects seemed small and far away, without headache (Gowers states that this is an occasional aura in epilepsy and may occur alone). At the age of 20 the patient had attacks in the early morning which lasted for a few seconds and were characterized by a peculiar flavor and a brief dreamy sensation lasting for a few seconds. After these had gone on for a few weeks, a distinct epileptic convulsion occurred in the afternoon but no more. Other minor attacks followed, now a sense of smell, not of flavor, and a brief confused feeling, instead of a 'dreamy' state. These ceased, and the headaches returned which had been absent during the epileptic period, but they were no longer preceded by the visual sensation. They ceased, however, on the return of still slighter minor attacks without any sensation, consisting only of a brief inability to speak, so brief as to be seldom noticed. After a time, these also ceased, and there was no recurrence of the headaches.

The question that naturally occurs to any one who has seen migraine and epilepsy in the same patient, or who has studied the cases reported in the literature, is whether there is a definite etiologic and pathologic relationship between the two conditions, or whether the occurrence of the two conditions in one individual is entirely a coincidence. In both diseases we sometimes have an aura, though in migraine the aura, which often appears as numbness of the upper extremities, is likely to be prolonged for thirty minutes or an hour. In both diseases the attacks are followed by somnolence. One cannot be surprised that Wernicke,[4] in 1881, stated that migraine is often united with true epileptic symptoms, and is sometimes the forerunner of an epileptic attack. This relationship between the two neuroses has been accepted by Sieveking, Parry, Marshall Hall, Liveing, Charcot, Féré, Berbex and others.

A hereditary relationship between the two diseases has been observed by Moreau, Revington, Liveing and others. They call attention to the fact that not uncommonly one finds migraine in one brother or sister and epilepsy in the other. Féré mentions the fact that, from among 308 epileptic men, in eighty-eight cases the father, and in 116 cases the mother had had migraine; and that from among 288 epileptic women, the children of forty had migraine. On the other hand, other observers, in particular Krafft-Ebing[5] and Bernhart, hold the opinion that there is no close relationship between migraine and epilepsy. Gowers calls attention to the fact that there may be some relation between the two, but the actual evidence thereof is very slight. He says that in only a single case has he been able to deduce a direct relation, i. e., in this case the same premonition preceded the attacks both of epilepsy and of migraine. Gowers believes that we are hardly justified in saying more than that in each malady there appears to be a slow development of a state of nerve tension which is finally relieved by a violent functional disturbance. The character of this disturbance, however, differs very much in the two diseases. Gowers also calls attention to the difference between the sensory and the visual aurae in the two conditions. Rachford has attempted to show a definite relationship between epilepsy and migraine by the presence of increased amounts of paraxanthin in the urine in both diseases; but he reports only one case of epilepsy in which paraxanthin was found, though it appeared often in migraine.

A careful summary of the literature would lead one to believe that there is no very close relationship between the epileptiform attacks and the migraine, and that when convulsions do occur they are due to the vascular changes which occur during an attack of migraine. Some of the cases that are referred to in the literature, such as cases of petit mal in patients who have had migraine, are undoubtedly due to the psychic disturbance which results from the vascular instability which is seen during an attack and are not cases of minor epilepsy at all. That marked vascular disturbances do occur during the course of an attack of migraine is shown by the fact that the patient often has visual disturbances and may often have numbness or weakness in one extremity. The visual disturbances which are associated with migraine are probably due to spasm of the blood vessels supplying the occipital lobe. These visual disturbances may take the form of a bright light in front of the eye which gradually increases in size, or there may be a definite fortification spectrum on one side of the eye that is affected. This fortification spectrum may show many different colors and different arrangements. Sometimes the interference with vision is so marked as to cause temporary

2. Riesman, David: Hypertension in Women, J. A. M. A. 73: 330 (Aug. 2) 1919.
3. Gowers, W. R.: Brit. M. J. 2: 1617, 1906.
4. Wernicke, C.: Lehbuch der Gehirnkrankheiten, 1881.
5. Von Krafft-Ebing, R.: Ueber Hemikranie und deren Beziehungen zur Epilepsie und Hysterie, 1897.

blindness. It is not at all uncommon to find temporary aphasias, numbness or a paralysis in one upper extremity associated with these attacks of ophthalmic migraine. One can very easily imagine that when the vascular spasm is severe, and when it affects not only the sensory but also the motor area, particularly in individuals in whom the nervous system is unstable, an epileptiform convulsion will result. Just as some children will develop convulsions in the presence of a slight elevation of temperature, so certain individuals may develop convulsions as the result of any disturbance of the blood supply of the brain, particularly of a cerebral anemia. The association of cerebral anemia with migraine is evidenced by the fact that these patients often feel extremely faint and have marked vertigo. The presence of a vascular instability explains also the fact that many patients who have had migraine in earlier years develop convulsions at the time of the menopause, when arterial hypertension is likely to develop, particularly in persons of the obese type. On this basis could be explained also the development of epileptiform phenomena in elderly persons with well marked arteriosclerosis, especially arteriosclerosis of the cerebral type, such as was indicated in Case 1, reported above. In this case evidence of intermittent closing of the cerebral artery was presented by the attacks of transient aphasia, the convulsions developing later, as the arteriosclerosis with arterial hypertension became more marked. The correct assumption in this case could be that the more severe epileptiform attacks with convulsions were simply due to more severe attacks of vascular spasm with cerebral anemia.

According to my own experience, patients with migraine are much more subject to the development of arteriosclerosis, high blood pressure and chronic arterial nephritis than are other patients.

CONCLUSION

The epileptiform attacks which occasionally are associated with migraine would appear, like the migraine itself, to be due to some cardiovascular disturbance. That is, varying degrees of the disturbance which in one instance produces the aura, headache, and ophthalmic symptoms, which characterize a typical attack of migraine, in another may produce an aura of slightly different type with a convulsion. These epileptiform attacks, therefore, are incorrectly designated as "epilepsy." In the rare instances in which a true epilepsy does occur in an individual who is subject also to attacks of migraine, the occurrence is undoubtedly merely a coincidence without essential etiologic or pathologic relationship.

ABSTRACT OF DISCUSSION

DR. JULIUS GRINKER, Chicago: I agree with Dr. Phillips that epilepsy which occurs in migraine or follows migraine is not caused by migraine but by cardiovascular changes. The cardiovascular changes may be the cause of epileptiform convulsions which may occur in a patient the subject of migraine or in one who is free from migraine. There is, however, a relation between epilepsy and migraine. What that relation is we do not know. The cause of epilepsy is as little known as that of migraine. The fact is, we occasionally see patients with migraine who have epileptiform phenomena and vice versa. Years ago I saw a patient said to be suffering from epilepsy who was about to be subjected to Reed's abdominal operation. I diagnosed true migraine with so-called epileptiform phenomena. There was temporary weakness in the lower extremities and transient loss of vision, which was interpreted as epilepsy with loss of consciousness. It was merely an unusual phenomenon accompanying certain forms of migraine. I saved him from Reed's mutilating and dangerous operation. I gave him cannabis indica in the usual way, and he has been free from migraine for twelve years and is not now the subject of cardiovascular changes. I do not believe that many patients develop cardiovascular changes on account of migraine. Patients with migraine with motor phenomena are sometimes treated for syphilis. A patient who had migraine had an apoplectiform attack in one extremity, which was interpreted by his physician as syphilis. The diagnosis was incorrect. The patient has remained well for many years after a course of intensive treatment with cannabis indica. Migraine is peculiar in that it may also simulate several organic diseases. I am glad Dr. Phillips brought out that, while epilepsy may occur in a migraine patient, the epilepsy is not caused by the migraine, but is the result of cardiovascular changes. Migraine and epilepsy are associated in some way. A mother may have migraine and the daughter may suffer from epilepsy. For diagnosis it is well to know that when a patient comes with an uncertain description of an attack which may be taken as epileptiform, while the mother gives a history of migraine, one must seriously consider epilepsy in the child, and that the opposite may also occur.

DR. JOHN PHILLIPS, Cleveland: I have nothing further to add, except to emphasize the points Dr. Grinker has brought out and to state that I believe that cases of migraine are often incorrectly diagnosed as epilepsy of the petit mal type or other organic diseases of the central nervous system.

SOME POINTS IN PHYSICAL DIAGNOSIS*

DAVID RIESMAN, M.D.
PHILADELPHIA

The four topics I have chosen for discussion are perhaps not of fundamental importance, but will, I hope, prove of value to the clinician. I shall present them with utmost brevity.

MOVABLE DULNESS NOT ALWAYS A SIGN OF FLUID

It is almost universally believed that movable dulness in the chest is a sign of the presence of fluid. So firmly is this belief held that when the other signs of effusion are equivocal, this one is commonly permitted to determine the diagnosis. I should like to point out, however, that in some instances movable dulness is produced by another cause.

In the cases that I have in mind, what seems to be fluid is in reality the liver changing its position. When the patient is sitting up or standing, the liver is found to be one or two interspaces higher than it is when he is lying down, a striking change in resonance being in consequence produced. I take it that when this phenomenon occurs, it is due to a softness of the liver, causing it to rise when the patient stands up and to fall when he lies down. It is possible that the state of tonus of the diaphragm is an additional factor in its production.

In order not to be misled, it is necessary to locate carefully the apex beat, and to determine whether or not it is displaced to the left. One must also look for movable dulness in the axilla, as well as in front; and in very obscure cases recourse must be had to the roentgen ray or to tapping.

ULNAR PERCUSSION

In a number of obscure cases of suspected gallbladder disease, the ordinary method of eliciting tenderness proves fruitless. The discovery of a tender area

* Read before the Association of American Physicians, Washington, D. C., May 2, 1922.

would greatly aid in the diagnosis, yet one may press as firmly as is justifiable, and the patient will not complain. For such cases, the late John B. Murphy recommended fist percussion. That, however, appears brutal, and may not be without risk. As a substitute for it, I have found ulnar percussion very satisfactory; others, I am quite sure, have had the same experience.

The method of employing it is simple: The patient is asked to take as deep a breath as possible and to hold it. Then suddenly one strikes a quick but not hard blow over the upper part of the right rectus muscle, with the ulnar side of the hand. If there is any disease of the gallbladder, the blow will cause a sharp pain. If one is in doubt as to whether this pain is superficial and due to the blow on the integument, all that is necessary is to perform the test on the left side.

The same method of ulnar percussion is applicable to the determination of sensitiveness over the kidneys. By striking the loin at right angles to the long axis, it is possible to localize pain due to stone or to inflammation in and about the kidney. I am quite sure that it permits of a sharper localization than does fist percussion. Here, also, it is necessary to compare the two sides.

CLAVICULAR AUSCULTATION

It is often of interest to determine whether or not an aortic murmur is transmitted into the neck. By the customary method of placing the stethoscope over the cervical vessels, a murmur is at times created by pressure. Even a very gentle application of the stethoscope may produce a murmur. To avoid this source of error the stethoscope, which must be either a Bowles or some other form of diaphragm stethoscope, should be placed over the clavicle. If the murmur is a transmissible one, it will be well heard all along the bone, where no artery can possibly be pressed upon.

This method is also of value in another respect. Frequently one encounters cases of marked hypertension, in which by every rule the aortic second sound should be accentuated, but in which it is found not to be loud. In a number of such cases, in which the second sound at the aortic area was not at all in keeping with the height of the pressure, I have heard a loud second sound over the clavicles. I would explain this anomaly on the theory that some extrinsic mechanical factor interferes with the transmission of the intensified second sound to the usual place of auscultating, in the second right interspace. The same factors do not interfere with the audibility of the sound over the clavicles. This is really a very striking phenomenon, although not a common one.

Diastolic aortic murmurs are also often well heard over the collar bone.

TRANSDIGITAL AUSCULTATION

Timing heart murmurs is not always easy. This is particularly true of mitral murmurs. The question frequently arises as to whether one is dealing with stenosis or with regurgitation at the valve orifice. Timing by means of the radial pulse is unreliable, and by means of the carotid is also not very satisfactory. Several years ago I described a method that has proved of considerable help in this matter. I have called it "transdigital auscultation." To practice it, it is necessary to employ a diaphragm stethoscope, and not one of the bell type. The index or middle finger is flexed at a right angle, and its tip is placed directly over the apex beat. The stethoscope is then laid on the horizontal phalanx of the flexed finger, at the angle. It will be found that murmurs may be heard nearly as well through the finger as when the stethoscope is placed directly on the chest; and, since auscultation and palpation are performed at the same place, it is obvious that one can tell readily whether a murmur occurs before the finger is lifted, synchronously with the lifting, or afterward. The method also serves well for eliciting the Duroziez murmur in cases of aortic insufficiency. This murmur, really a double murmur, is heard in the femoral artery when pressure is made on it with the stethoscope just below Poupart's ligament. Sometimes the pressure is distinctly painful; at others, the stethoscope disk is too large for making satisfactory compression. If the artery is not properly compressed, only one sound is heard. By transdigital auscultation, the drawbacks just cited are obviated—the to and fro murmur can readily be brought out by regulated pressure with the tip of the finger.

1715 Spruce Street.

Clinical Notes, Suggestions, and New Instruments

SIMPLE PROTECTION FOR NEWLY PLACED SKIN GRAFTS

FRANK WARD SMYTHE, M.D., MEMPHIS, TENN.

Having used such substances as paraffin gauze, perforated rubber tissue and tinfoil to protect newly placed Thiersch skin grafts, and not being entirely satisfied because they

Wire protection for skin grafts; grafted areas darkened.

came in contact with the grafts, and also because the wound could not be inspected thoroughly without disturbance, several years ago I began using another method, which has proved entirely satisfactory.

The grafts, having been placed over the raw surface, are covered with a piece of Wright's flexible wire splint, cut to the size needed and bent somewhat like the Greek capital omega (Ω). This bending gives a smooth base for the protection apparatus to rest on, and also arches the surface so that it does not come in contact with the graft area.

Beneath the bases of the apparatus are placed several thicknesses of sterile gauze to protect the underlying skin from pressure. Next, strips of adhesive are placed over the flanged part of the wire, which extends outward across the gauze padding to the skin. This firmly fixes the apparatus in place.

Over this arched wire covering, the gauze or bandage dressing is applied. When the wound is to be inspected, all there is to do is to remove the dressing, leaving the wire protection in place; thus there is no disturbance of the graft area.

I have used various kinds of material for making this simple apparatus, but finally decided on a piece of Wright's flexible wire splint because it is light, easily bends to the desired shape, and is strong enough to support any kind of dressing; its holes are amply large for one to observe the wound, and it can be sterilized.

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SATURDAY, JUNE 24, 1922

LAXATIVES AND BLOOD CONCENTRATION

The use of laxatives and purgatives is so widespread, and their administration is so largely independent of medical advice, that any untoward effects attributable to these drugs may easily escape notice. Lately a number of instances of cutaneous manifestations due to the use of phenolphthalein as a laxative drug have been brought to the attention of physicians, particularly by dermatologists to whom the puzzling cases of dermatitis have been referred for diagnosis.[1] Phenolphthalein is only one of the substances—almost countless mixtures, either as pharmacopeial preparations or as proprietary concoctions—belonging to the category of "household remedies." How they act and what harm they may institute under exceptional cases is rarely asked; for laxatives have come to be looked on solely as "unmixed blessings." Yet it requires little study of available scientific literature to bring conviction that the ideal evacuant is still to be described.

The saline laxatives probably enjoy at present a greater popularity than any other group. Underhill and Errico [2] have recently demonstrated that when magnesium sulphate (Epsom salt), sodium sulphate (Glauber's salt) or potassium and sodium tartrate (Rochelle salt) are administered experimentally in doses capable of producing diarrhea, a distinct concentration of the blood may take place, whereas no such phenomenon attends the laxative use of castor oil or of cascara sagrada, as representatives of the group of vegetable purgatives. Evidently the water discharged through the bowel movements is derived from the blood and tissues in the cases in which the saline compounds mentioned are employed. Ordinarily such concentration of the circulating medium would excite little interest. But since the studies of the effect of the lethal war gas, as well as of influenzal and other types of pneumonia, have assigned to blood concentration a pathologic significance not recognized or at least not duly appreciated a few years ago, it is quite conceivable that undue concentration of the blood from any cause may lead to distressing symptoms. According to Underhill's comprehensive studies in this field, concentration of the blood is not of itself dangerous until a point about 125 per cent. above normal has been reached. However, despite this large "factor of safety," the advice of Underhill and Errico seems timely. The fact that purgatives exert a definite influence in the direction of concentrating the blood indicates that care should be exercised in the administration of purgatives in disease conditions, especially in those states known to be responsible for concentrated blood. By the ill-advised use of purgatives, these authors state, it is apparent that blood concentrated to some extent, and yet not sufficently concentrated to be dangerous in itself, may reach a dangerous concentration by the added influence of the purgative. Such a factor may account in part for the collapse which at times follows the administration of a purgative.

Pharmacologists have repeatedly pointed out [3] in connection with the use of saline evacuants that probably moderately dilute solutions would be more serviceable than the concentrated ones commonly used. The latter are preferred because of the lessened time required to drink a disagreeably bitter dose; but unless the removal of an excess of water from the tissues is one of the ends sought, such laxatives should always be subsequently diluted by an adequate water intake. Hatcher and Wilbert [3] have pointed out that one especial advantage which natural mineral waters have over the solutions of purgative salts, as usually employed, is that they are very dilute, and the patient is thus required to consume a fairly large amount of water with them. This advantage can be secured so easily, however, by attention to the proper dilution of purgative salts that it is not sufficient to justify the expense of the natural waters.

1. Ayers, Samuel, Jr.: Phenolphthalein Dermatitis, J. A. M. A. **77**: 1722 (Nov. 26) 1921. Wise, Fred, and Abramowitz, E. W.: Phenolphthalein Eruptions, Arch. Dermat. & Syph. **5**: 297 (March) 1922.

2. Underhill, F. P., and Errico, L.: The Influence of Purgatives on Blood Concentration, J. Pharmacol. & Exper. Therap. **19**: 135 (March) 1922.

3. Hatcher, R. A., and Wilbert, M. I.: Pharmacology of Useful Drugs, Chicago, American Medical Association, p. 293.

THE WATCH AND THE PULSE RATE

It often happens that the things which are nearest to us in everyday life give us least concern, for they seem to be part and parcel of the routine of existence. Usually some extraordinary occasion is required to awaken an appreciation of an undervalued factor which may represent the outcome of a long struggle for acquisition, or tedious years of investigation. Serious disease menaces of a few decades ago may be forgotten in the security that modern preventive medicine or sanitary science has afforded. With the blessing of anesthetic and analgesic drugs at our disposal, the days of unallayed pain in the experience of the physician seem ancient and almost mythical. Fortified with the stethoscope and the hypodermic syringe, the practitioner follows his duty with little thought of the times,

not so long ago, when there were few helps to success other than his unaided senses, his native ingenuity, and a few traditional concoctions or procedures.

No detail in medical practice is repeated more frequently than is the counting of the pulse. The physician is commonly pictured, watch in hand, determining the rate of the heart beat through count of the arterial pulse. An accurate estimate of this factor requires an instrument of precision to mark some definite interval of time. The timepieces now in use are comparatively modern inventions. In his Fitzpatrick lectures on Greek Medicine in Rome, Sir Clifford Allbutt [1] has designated Herophilus as the first physician to count the pulse—it is said by a water-tube clock—and thus to bring it definitely into semeiology. It is occasionally stated that the German cardinal Nikolaus Krebs of Cues on the Moselle, who lived in the fifteenth century, suggested devices for counting the pulse, though there is no evidence that his schemes were ever carried out. Galileo counted the pulse by means of a pendulum; and the late S. Weir Mitchell [2] has left an interesting account of the pulsilogium of those earlier days when real timekeepers suitable for pulse counting did not yet exist.

In a recent essay on the history of pulse timing, Rosenbloom [3] of Pittsburgh has called attention anew to the deserts of Sir John Floyer as the first of the moderns to make regular observations on the rate of the pulse, counting the number of beats in the minute by the watch. Before this time, though other points connected with the pulse had been extensively studied and pulse doctrines abounded in great numbers, the record factor had been neglected. The ordinary watch used in Floyer's time had only a single hand. It recorded neither minutes nor seconds. Floyer's "physician's pulse watch" ran only sixty seconds, the date 1707 marking the year of the announcement of its medical application.[4]

In these times, when even seconds count much, it seems odd to hark back to a period only two centuries ago, when evidently the minute had not yet entered the daily life of man. While the doctrine of the specific pulses—a pulse for every malady—was dying hard in the days of "observation gone minutely mad, a whole Lilliput of symptoms, an exasperating waste of human intelligence," as Mitchell has written, the pulse rate so much stressed in these later years was rarely heard of. It seems incredible, says Mitchell, but not until the later French school developed its force can one find in reports of cases the beginnings of those systematic numerations of the breath and the pulse which are encountered in modern case records. It remained for the influence of the great Dublin school, to which Riesman [5] has lately paid literary tribute, to bring about conditions under which the familiar figure of the physician, watch in hand, has become commonplace. This timepiece has become a medical instrument of precision, and has given accuracy to the estimate of the heart rate. "We could better lose this knowledge," Mitchell has written, "than the rest of what the pulse teaches, and yet it is the only pulse sign we can put on paper with perfect precision, as Heberden remarked a hundred years ago."

1. Allbutt, T. C.: Greek Medicine in Rome, London, Macmillan & Co., 1921.
2. Mitchell, S. W.: The Early History of Instrumental Precision in Medicine, Tr. Cong. Am. Physicians and Surg. **2**: 174, 1891.
3. Rosenbloom, J.: The History of Pulse Timing, with Some Remarks on Sir John Floyer and His Physician's Pulse Watch, Ann. Med. Hist. **4**: 97 (March) 1922.
4. Floyer, J.: The Physician's Pulse Watch, **1**, 1707; **2**, 1710.

TUBERCLE BACILLI AND LIVING CELLS

In a lecture on tuberculous infection, before the Harvey Society of New York, Krause [6] remarked that, at its culmination, every case of tuberculosis represents, in some degree, the fruition of a long sequence of accidental circumstances. The tubercle bacillus, gaining entrance into the organism through some mucous surface, is brought into contact with a considerable variety of tissues composed of living cells. Presently a place of focalization may be reached from which at a subsequent period new paths of dissemination are followed in the organism, so that there must continually be some possibility of interrelation between the bacilli and tissue cells from which either group may suffer.

Of late, considerable attention has been directed to the behavior of living cells toward foreign particles. The introduction of ready methods of tissue culture has greatly facilitated such studies. Phagocytosis has, of course, long been recognized as an instance of reaction between cells and environmental substances. What the nature of the response on the part of irritable protoplasm is remains unsettled. A recent writer has remarked that the long familiar hypothesis by which the cell makes purposeful movements toward taking in a foreign body, and ingests or engulfs it, is rapidly being replaced by the more recent interpretation that the coming together of the cell and the foreign body is a purely chance occurrence, and that the taking in of the foreign body is a physical phenomenon.

An investigation of the behavior of tubercle bacilli in tissue cultures by Smith, Willis and Lewis [7] at the Johns Hopkins Hospital has shown that these micro-organisms can be taken in by many types of cells—clasmatocytes, fibroblasts, white blood cells, endothelial cells, mesothelial cells, ectodermal cells, liver cells, kidney tubule cells, and cells lining the bronchioles and alveoli of the lungs. No micro-organisms were observed in red blood cells, striated muscle cells, nerve cells, or ciliated epithelial cells subjected to the bacilli. The phenomena accompanying the appearance of tuber-

5. Riesman, D.: The Dublin Medical School and Its Influence upon Medicine in America, Ann. Med. Hist. **4**: 86 (March) 1922.
6. Krause, A.: Experimental Studies on Tuberculous Infection, Am. Rev. Tuberc. **6**: 1 (March) 1922.
7. Smith, D. T.; Willis, H. S., and Lewis, M. R.: The Behavior of Cultures of Chick Embryo Tissue Containing Avian Tubercle Bacilli, Am. Rev. Tuberc. **6**: 21 (March) 1922.

cle bacilli within these cells were precisely the same as those shown by similar cells in regard to other foreign bodies. Entrance into cells was dependent on the consistency of the cytoplasm of the cell, the composition of the foreign body, and also the position of the foreign body in relation to the surface of the cell. Contrary to the generally accepted idea, the cell did not make any active movements toward the bacillus, nor was any migration of bacilli toward the cell observed. Once inside the cell, the bacilli were moved back and forth in the cytoplasm in a manner characteristic of included foreign bodies. In course of time a small vacuole formed about the micro-organism, which was eventually destroyed. It is quite conceivable that, in the living body, the presence of some tissue component or circulating chemical substance might lead to a different reaction between cell and bacterium. Perhaps the capacity of cells to master the tubercle bacilli under appropriate conditions without appearance of unusual cellular phenomena may help to explain in part how the organism, which may be presumed to be subject to repeated invasions by a widely distributed particulate enemy, after all scores so many successes in the fight against it.

RICKETS IN INDIA

In his Cutter Lecture on the rickets problem, at the Harvard Medical School a few weeks ago, Hess [1] remarked that advance in our knowledge of this disease promises to be greater during this decade than throughout the preceding 250 years. The newer studies of nutrition have been responsible for the support of the view that dietary deficiencies play a very significant part in the etiology of rickets. Thus it has become possible, by means of carefully controlled changes in the regimen, to produce experimentally in animals an almost exact analogue of rickets in children. The abnormal deposition of calcium salts so characteristic of the bones can be instigated in several ways involving the lack of one or more now recognized essentials of the diet. However, rickets occurs at times in human cases under conditions in which the food supply seems to be beyond serious criticism with respect to calcium, phosphorus, protein or vitamins, deficiencies of all of which have been believed to contribute to a disturbance in the metabolism of the osseous tissues. In instances of this sort, hygienic conditions, such as the lack of fresh air and exercise, have been vaguely proclaimed as the determining causative factors. Referring to the rôle of environmental factors, Hess remarks that, after years of discussion and disagreement, those who upheld the dietetic theory, as well as those who maintained the hygienic theory of origin, have been found to be right. It has been clearly demonstrated that rickets can be prevented or cured by means of light rays—either the artificial rays of the mercury vapor quartz lamp, or by sunlight. The fact that such dissimilar agents as diet and sunlight can both be of prime importance in connection with the origin and cure of a disease has not only tended to a broader conception of rickets, but, Hess adds, has also led to a larger point of view of nutritional disorders in general—an attitude that will undoubtedly prove fruitful.

The association of rickets with poverty and overcrowding can now readily be interpreted as due to either poor diet or lack of sunlight, or both. It has begun to appear, however, that the disease is by no means missing among the families of the well-to-do. A most interesting study of the relation of rickets to diet and environment has been made in the Nasik district of the Bombay Presidency by Hutchison and Shah.[2] There the population is made up of two strata: an upper class of well-to-do Hindus, and a lower group of laborers who are uneducated and poor. Rickets occurs almost exclusively among the better situated first class. Their dietary appears to be far superior to that of the poorer classes, among whom the disease is almost completely absent. The larger consumption of milk and ghee (native butter) entails to the most extensively suffering class a greater supply of vitamin A, lack of which has been charged by English writers in particular with responsibility for the genesis of rickets. On the other hand, the mode of life enforced by social and religious customs on this group of persons, particularly among women and children who live mostly indoors, screened from public view, leads to a lack of fresh air, sunlight and exercise. Hence Hutchison looks on these as the most important etiologic factors in the production of rickets among the people referred to.

Hess [1] has given reasons for identifying the firmly established hygienic factor in the etiology largely with an adequate supply of sunlight. Its curative properties can be replaced by the rays of the mercury vapor lamp. Several years ago, the Glasgow school,[3] which has always been unswerving in its advocacy of the environmental etiologic factor, attempted a crucial experiment by keeping one lot of pups in the laboratory on a liberal diet of whole milk and porridge, while a duplicate lot was kept in the country on skim milk and oatmeal. The former developed rickets, while the latter failed to do so. Hutchison points out that the conditions observed by him in man in India are similar to the canine experiments. We must abandon the idea that rickets is necessarily a disease of poverty. Indeed, it is not missing in the breast-fed infants of the well-to-do. Furthermore, late rickets, or rachitis tarda, the disease found as late as the twentieth year of life in persons previously healthy and nonrachitic, has been

1. Hess, A. F.: Newer Aspects of the Rickets Problem, J. A. M. A. 78: 1177 (April 22) 1922.

2. Hutchison, H. S., and Shah, S. J.: The Aetiology of Rickets, Early and Late, Quart. J. Med. 15: 167 (Jan.) 1922.

3. Paton, D. N.; Findlay, L., and Watson, A.: Brit. M. J. 2: 625 (Dec. 7) 1918.

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discovered in India to be confined to women even on good dietaries who observed the purdah life of indoor existence. Thus sunlight has once more been demonstrated to be the enemy of disease.

Current Comment

TARANTULA TOXICITY

Folk-lore abounds in stories of phenomenal manifestations which often fail to survive the test of critical examination. Accounts of unexpected occurrences or unusual symptoms often grow like rolling snowballs, adding to their size with each step in the course of progress. Small effects may become magnified into great ones; suspicions develop somehow into the dignity of probabilities or even real facts. New traditions seem to spring up from undiscovered sources. Something of the nature of such mystic influences may account for the prevalent belief in the extreme danger associated with the tarantula. The fatal bite of these terror-inspiring insects has been widely proclaimed, so that they are given a wide berth by those who recognize them. The poisonous properties of various species of spiders is admitted by competent investigators.[1] Many of the insects have poison-secreting glands which discharge into the jaws. But there is little doubt that the danger from some of them has been greatly exaggerated.[2] Von Fürth [3] considers that the bite of the historically famous Italian tarantula is able to cause no more than local inflammation, while the toxicologist Kobert was unable to discover profoundly poisonous properties in the supposedly more dangerous Russian tarantula. Now the American tarantula, *Eurypelma steindachneri*, a species reaching the formidable looking adult size of more than 2 inches in length, has been exonerated from the reputation long attaching to it. Baerg [4] of the University of Arkansas has subjected both animals and man to attack by the fangs of active tarantulas. Although the accounts do not give the impression that such encounters are painless performances, they are put in the category of bee sting in severity rather than into the class of more menacing toxins. Even bees may produce fatalities; yet they are rarely classed among the greater dangers to life.

MEAT AND SCURVY

The fact that scurvy is not peculiarly prevalent among the peoples of the Far North living for the most part on animal food, who rarely have available those vegetable products which are prized as antiscorbutics, has been the subject of considerable discussion since the recent renewal of interest in a long known disease. Those investigators who have tested the protective power of meat against scurvy on the classic experimental animal, the guinea-pig, have almost without exception failed to demonstrate any antiscorbutic potency in muscle tissue. Against these findings stand the statements of Stefánsson [1] that scurvy was avoided during his arctic explorations by the use of large quantities of meat from freshly killed game, the tissue usually being eaten raw. The experimental investigations of Vedder [2] of the U. S. Army at Fort Sam Houston, Texas, corroborate the previous guinea-pig tests in showing that the administration of considerable amounts of erythrocytes, voluntary muscle, heart muscle and bone all failed to prevent the development of scurvy, or even to prolong the depletion period. The antiscorbutic factor is not present in these tissues in appreciable quantity. On the other hand, various viscera—the liver, lungs, spleen and pancreas—as well as the brain evidently possess antiscorbutic powers, as has long been known for the liver in particular. This demonstration in respect to glandular organs may account for native customs among tribes who live chiefly on a meat diet. Many of them esteem the organs as dietary tidbits. Vedder states that when the plains Indian had been without game over a considerable period, he was accustomed to open the freshly killed bison and eat handfuls of raw liver. It is stated that the Eskimos make a special effort to secure the liver of the seal, and that when hunters had Apache Indians as guides, the usual bargain was for the guides to take all the insides of the deer, leaving the meat for the hunters. Perhaps the seemingly unusual customs become susceptible of a plausible explanation in the light of the newer knowledge of nutrition. Perhaps, further, the distinction between meat, in the sense of muscular tissues, and glandular organs such as the liver and kidney, has not always been made by those who have reported dietary habits in relation to human scurvy.

SUCCESSFUL FIRST AID

"In August, 1921, a miner at Shock, Ky., was rendered unconscious by electric shock. A fellow miner, trained in first aid, immediately administered the Schaefer method of artificial resuscitation and saved the man's life." This is one of several instances of successful first-aid treatment by fellow workmen recently published by the Bureau of Mines in a report of investigation. The report is a reminder that certain knowledge and practices regarding first aid should be more generally known by the public. Accidents occur frequently, when physicians are inaccessible, but when immediate assistance may be of the utmost importance, as shown in another instance in this report. In this case a comrade made a tourniquet of his suspenders and stopped a hemorrhage that would have been fatal if this immediate aid had not been rendered. These men had been trained in first aid, and with that training

1. Faust, E. S.: Die tierischen Gifte, Braunschweig, 1906.
2. Wells, H. G.: Chemical Pathology, Philadelphia, W. B. Saunders Company, 1920, p. 150.
3. Von Fürth, O.: Vergleichende chemische Physiologie der niederen Tiere, Jena, 1903.
4. Baerg, W. J.: Regarding the Habits of Tarantulas and the Effects of Their Poison, Scient. Mont. 14:482 (May) 1922.

1. Stefánsson, Vilhjálmur: Original Observations on Scurvy, M. Rev. of Rev. 24:257, 1918; Observations on Three Cases of Scurvy, J. A. M. A. 71:1715 (Nov. 23) 1918.
2. Vedder, E. B.: The Etiology of Scurvy, IV, Observations Concerning the Physiologic Action of the Antiscorbutic Vitaliment, Mil. Surgeon 50:534 (May) 1922.

they were enabled to save lives. A host of American citizens—soldiers, Boy Scouts, and others—have been so trained, but the great mass of citizens are entirely ignorant of the principles of first aid to the injured.

Medical News

(PHYSICIANS WILL CONFER A FAVOR BY SENDING FOR THIS DEPARTMENT ITEMS OF NEWS OF MORE OR LESS GENERAL INTEREST: SUCH AS RELATE TO SOCIETY ACTIVITIES, NEW HOSPITALS, EDUCATION, PUBLIC HEALTH, ETC.)

ALABAMA

Eradication of Typhoid Fever in the State.—According to statements by the state board of health, there has been a great reduction in the number of deaths from typhoid fever during the five years, ending Sept. 30, 1921. For the year ending September, 1917, the total number of victims of typhoid fever in Alabama, as reported to the Bureau of Vital Statistics, was 979, or 43.19 per hundred thousand population. By the adoption of all known modern methods of control and prevention, this number was reduced to 372 for the year ending Sept. 30, 1921, or 14.40 per hundred thousand population.

ARKANSAS

University of Arkansas.—With the resumption of the junior and senior years, the opening of the University of Arkansas Medical Department, Little Rock, will be augmented with an additional staff of instructors and full clinical facilities, it was recently announced by Dr. Morgan Smith, dean of the school. Under the new plan the city hospital, St. Vincent's Infirmary, St. Luke's Hospital and the Baptist State Hospital officially become affiliated with the school of medicine. The new curriculum will include a department of hygiene and public health, an innovation at the school. A special degree will be awarded those who successfully complete the course. Dr. Charles W. Garrison has been named professor of hygiene and public health, to serve during his term as state health officer.

CALIFORNIA

Honor for Physician.—A monument erected to the memory of the late Dr. George Waldo Bryant of Truckee, Nevada County, who died, March 14, was unveiled at the local cemetery, June 3, with impressive ceremonies. It bears the inscription "Sacred to a Faithful Friend and Public Benefactor, George Waldo Bryant, M.D., 1874-1922."

Board of Health Budget.—The San Francisco Board of Health budget for the coming fiscal year has been submitted and totals $4,000,000. This includes $15,000 for radium, $11,000 for a building to house women discharged from state institutions, $1,500,000 for new buildings at the Relief Home, and $500,000 for a new board of health building.

Personal.—Dr. Walter Lenker has been appointed county health officer, county physician and superintendent of the county hospital of San Bernardino County. These three positions have recently been combined, in an effort to advance the program of public health and medical improvement.——Dr. Ethel M. Watters, pediatrician and director of the bureau of child hygiene on the state board of health at San Francisco since 1919, has resigned to accept the position as consultant in the administration of the Sheppard-Towner Maternity Act.

CONNECTICUT

Personal.—Dr. Ross G. Harrison, Yale University, New Haven, has been elected an honorary member of the Royal Academy of Medicine of Turin.——Dr. Israel S. Otis has been appointed city physician of Meriden to succeed Dr. Howard DeForest Lockwood.

Yale-in-China Anniversary.—The twentieth anniversary meeting of the Hunan-Yale College of Medicine, Changsha, China, was held, June 18, in the Battell Chapel, Yale University, New Haven, during the two hundred and twenty-first commencement exercises of the university. Dr. F. C. Yen, principal of the Hunan-Yale College, and Dr. Edward H. Hume, chief of the medical department and general secretary of the college, spoke on the situation in China with reference to medical education. Charles B. Chatfield has been appointed in charge of the chemistry department for a period of two years. Dr. Arthur B. Dayton, New Haven, will sail for China, in July, to teach in the department of medicine at Changsha.

DISTRICT OF COLUMBIA

Housing Legislation Favorably Reported.—The committee on the District of Columbia has favorably reported the Ball bill designed in the interest of public health, comfort and morals, to discontinue the use of dwellings or buildings situated in alleys in the District of Columbia. The measure has already passed the Senate. Some minor amendments were included in the report to the House.

FLORIDA

Removal of Veterans' Bureau.—The state medical clinic, under the direction of the Florida division of the U. S. Veterans' Bureau, has moved its quarters at Jacksonville to the St. James Building. Capt. E. M. Bradshaw, subdistrict manager in charge of the Florida district headquarters, in announcing completion of the removal of the medical clinic to its new quarters, containing about 2,500 square feet of floor space, stated that the change would facilitate the work of passing on applications for benefits allowed by the Veterans' Bureau, in cases of former service men who incurred permanent disabilities during the World War.

GEORGIA

Tonsil and Adenoids Clinic.—Under the auspices of the department of child hygiene, the state board of health and the Parent Teachers Association, the first of several tonsil and adenoid clinics was recently held in Wilkes County. Dr. Arthur G. Fort, Atlanta, was in charge of the work.

New Medical Society.—The physicians of La Grange organized the La Grange Medical Association at a meeting held, June 1. This organization will be entirely independent of the Troup County Medical Society. Dr. Henry R. Slack was elected president of the new organization; Dr. Emory R. Park, vice president, and Dr. Emery C. Herman, secretary-treasurer. The primary purpose of this organization was to care for the medical library and to supervise the purchasing of additional volumes.

IDAHO

Medical Meetings.—The thirtieth annual meeting of the Idaho State Medical Association will be held in Wallace, July 10-11, under the presidency of Dr. Max T. Smith. The Pacific Northwest Medical Association will convene in Spokane, Wash., July 6-8. The Spokane Medical Society has arranged a caravan to transport the physicians attending the Spokane meeting to Wallace, Idaho, through the Fourth of July Canyon. The physicians of the Northwest are invited to attend the state meeting as guests of the Idaho State Medical Association and the Wallace Board of Trade.

ILLINOIS

Hospital News.—The cornerstone of the new Rickly Memorial Hospital, Springfield, will be laid, June 27.——The new World War veterans building at the Elgin State Hospital was dedicated, May 28. The building was erected at a cost of approximately $150,000 and will accommodate 250 patients. ——The cornerstone of the new $300,000 Victory Memorial Hospital at Waukegan will be laid shortly.——On May 12, the cornerstone of the St. John or Huber Memorial Hospital Nurses' Home, Pana, was laid.——The cornerstone of the new Clinton County Hospital, Girard, was laid recently.

Personal.—Dr. Walter D. Stevenson, Quincy, has sailed for Europe, where he will take graduate courses in Vienna, Berlin and London.——Harry V. Atkinson, B.S., University of Illinois Medical School, has been appointed associate professor of pharmacology at the University of Texas Department of Medicine, Galveston.——Dr. Harry H. Hanly, Peoria, has been appointed a member of the state board of registration and education to succeed Dr. Lewis C. Taylor, Springfield, who resigned recently.——Dr. Albert E. Brown has resigned as county physician and superintendent of the Lake County General Hospital, Waukegan, to become effective, June 30.

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Chicago

Health Training for Railway Employees.—At the annual convention of the Baltimore and Ohio Association of Railroad Surgeons in Chicago recently, a campaign to educate railroad employees regarding the danger of contagious and social diseases was initiated.

Personal.—Dr. Walter W. Hamburger has resigned as assistant professor of medicine at Rush Medical College, and has accepted the position of associate professor of medicine at Northwestern University Medical School.——Dr. Blanche A. Burgner was elected president of the Chicago Medical Women's Club, June 14.

A Plan for More Adequate Dental Service in Chicago.—As a foundation for a program for more adequate dental facilities in Chicago, a study of the systems for dental care in some large cities of the United States was made at the direction of Julius Rosenwald by Michael M. Davis, Jr. Rochester, N. Y., says Mr. Davis in his report, has the most comprehensive plan for dental work for children in this country. The center of Rochester's dental system is the Rochester Dental Dispensary, an institution founded by Mr. George Eastman, but governed by a board of directors, of which twelve are leading business men. The city in no way controls the institution, but contributes annually to pay for prophylactic dental work for schoolchildren. The average cost of visits to the dispensary in 1920 was $1.42. The cost of the dental department per chair was about $1,500, making an allowance for overhead. The centralized supervision of dental work in the schools through affiliation with the Rochester Dental Dispensary is one of the distinctive features of this plan. A system of school clinics without an affiliated central institution, such as that of Detroit, suffers severely in contrast. A plan, similar in some respects to that of Rochester, is recommended for Chicago by Mr. Davis. It should be developed, he suggests, under the following system: (1) a central institution of approximately sixty chairs; (2) four branches, approximately thirty chairs each; (3) school clinics (for curative work) located in outlying districts and supplementing the branches; (4) dental prophylaxis and instruction in oral hygiene for all schoolchildren, to be done in the schools, according to the Rochester plan, by traveling squads of hygienists under centralized dental supervision; (5) the central institution to be under an independent board, but affiliated with medical and dental education, and with a general hospital; and (6) dental research to be an integral part of the program, and provided for in the facilities of the central institution.

INDIANA

Personal.—Dr. Nathaniel Bercovitz of Kachek, Hainan, China, is visiting the United States on a year's furlough. Dr. Bercovitz is a medical missionary under the Presbyterian Board of Foreign Missions, and the Central Presbyterian Church, Lafayette, is paying his salary.——Dr. Melville F. Johnson, Richmond, was elected president of the Sixth District Medical Association for a three-year term at the annual convention in Connersville.——Dr. Alfred G. Long, Cambridge, Mass., has been appointed superintendent of the laboratory of hygiene of the state board of health of Indiana, to succeed Dr. William Shimer, who has taken a position at St. Vincent's Hospital.——William A. Riley, Ph.D., entomologist, at the University of Minnesota, has been appointed one of three men, to spend the summer in Porto Rico, studying the hookworm and its effect on the natives of the island. Professor Riley spent last summer in New Orleans, studying yellow fever and malaria.

IOWA

Hospital News.—The contract has been let for the erection of a new hospital building at Estherville, to be built at a cost of $80,000.——Plans have been completed for a $125,000 addition to Iowa State Sanatorium, Oakdale.——Work will soon be started on a $40,000 addition to Sunnyslope Hospital, Ottumwa.——Plans have been completed for a new $100,000 addition to St. Joseph's Mercy Hospital, Webster City.

KANSAS

Examinations of Food Handlers.—An examination of 2,905 persons who are handlers of food was recently conducted in Kansas City, it is announced by the state health commissioner of that city. The new Kansas City health ordinance requires all restaurant employees, grocery men, and soda dispensers to be examined; and it is stated that the process has revealed a surprising ignorance or disregard of the elements of sanitation. Many concerned deserved to be classed as mentally, if not physically, unfit to handle the commodities sold. Of the 2,905 examined sixty-one were refused permits and 112 others either left the city or refrained from working in the lines affected by the examinations.

KENTUCKY

Venereal Disease Campaign.—The first three months of the war on venereal disease in Lexington, launched with the passage of an ordinance providing for the quarantine and treatment of men and women found to be a menace to public health through the possible spread of the disease, has demonstrated the great need for such work and has shown satisfactory results in remedying conditions, according to public health officials in charge of the work. All men and women arrested in raids on questionable houses and in similar circumstances will be subjected to a medical examination, and to treatment, if found diseased. The clinic is conducted on a charity basis, no charge being made for treatment.

LOUISIANA

Hospital News.—The Louisiana Antituberculosis Association has recently purchased 348 acres of land at Greenwell Springs for a tuberculosis hospital, one of the chain of hospitals planned for the control and extermination of tuberculosis. The league pledged itself to raise the entire sum to pay for the property, looking to the state for some contribution for maintenance. A hotel is situated on the site and could be easily adapted for a hospital with a 100-bed capacity. ——A bill for the establishment of a third state asylum for the insane, to be located in or near New Orleans, passed the Senate, June 7. This institution will be known as the Southern Psychopathic Hospital.——St. Simeon's School, New Orleans, has been purchased by Dr. B. F. Gallant and will be remodeled into a sanatorium.

MARYLAND

Radiophones to Be Installed in Hospital.—Dr. Winford H. Smith, superintendent, and Dr. Walter J. Craig, assistant superintendent, Johns Hopkins Hospital, have taken steps toward equipping all the wards of the hospital with wireless, so that all kinds of music and other forms of entertainment which the radiophone affords may be used to benefit the patients, especially convalescents who are inclined to fret at the long confinement in a hospital.

County Health Officers.—Dr. Harry M. Slade, Reisterstown, has been reappointed Baltimore County health officer, with the fifteen district health officers of the county; Dr. Lewis K. Woodward, Westminster, has been appointed health officer for Carroll County, with fourteen district health officers; Dr. Henry P. Fahrney, Frederick, has been appointed health officer of Frederick County; Dr. Norman S. Dudley, Church Hill, has been appointed county health officer for Queen Annes County.

Scarlet Fever in Counties.—The state department of health is using all the health forces of the state to combat the spread of scarlet fever throughout Maryland. The disease appeared in January in Wicomico County and has spread in varying degree to practically every county. Since the first of the year, 917 new cases have been reported. In May, the disease seemed to be under control, only eighty-seven new cases being reported during the month. Later, it was learned that many mild cases had been given no medical attention, and in some of the small eastern shore towns carriers had not been confined to their homes. Aside from scarlet fever, the health situation in Maryland is exceptionally good.

MASSACHUSETTS

Personal.—Dr. Nathaniel W. Faxon, assistant director of the Massachusetts General Hospital, Boston, has been appointed director of the Strong Memorial Hospital, which is to be the school of medicine and dentistry of the University of Rochester, N. Y. The hospital will have 220 beds, and will include the Rochester Dental Dispensary.

Mental Health of Children.—A course of fifteen lectures on mental health of children will be given in Boston University School of Education, on successive Monday evenings, from

Sept. 25 to Dec. 18, 1922, and Jan. 8 and 15, 1923. The lectures will be given under the direction of J. Mace Andress, Ph.D., head of the department of psychology and child study, Boston Normal School. The fee for a transferable course ticket is $10. Drs. Frankwood E. Williams, George K. Pratt, Abraham Myerson and Walter F. Dearborn will be among the lecturers.

MICHIGAN

Personal.—Dr. James G. Cumming, Ann Arbor, heads the list of participants in the city civil service commission's examination for chief of the bureau of health. Dr. Cumming received the degree of master of science in public health from Harvard University and, later the same degree from the University of Michigan. He has been engaged in public health research work for fifteen years, and is now connected with the U. S. Public Health Service in Washington, D. C. ——Dr. William DeKleine, health officer of Flint, has been appointed head of the Saginaw Health Department.——Dr. Claude W. Munger, superintendent, Blodgett Memorial Hospital, Grand Rapids, has been appointed to the editorial board of *Hospital Management.*

MINNESOTA

Hospital News.—A new building for the Bethesda Hospital, St. Paul, will be erected by the Lutherans on Capitol Hill. ——The tenth anniversary of the Nopeming Tuberculosis Sanatorium, near Duluth, was celebrated, May 23, with an all-day program. This sanatorium cares for 100 patients.

Medical Meeting.—At the second annual meeting of the Northern Minnesota Medical Association, in Detroit, Dr. Claude B. Lewis, St. Cloud, was elected president, and Dr. Willard L. Burnap, Fergus Falls, secretary-treasurer. Alexandria was selected as the meeting place for the next annual session. Drs. Bertram W. Sippy and Nelson M. Percy, Chicago, gave addresses at the meeting.

Personal.—Dr. Louis Blanchard Wilson has recently been awarded the Distinguished Service Medal for meritorious service to the United States government during the World War, as assistant to the director of laboratories and infectious diseases of the American Expeditionary Forces.——Dr. Edward W. Buckley, St. Paul, will receive the title of Chevalier of the Legion of Honor, in recognition of his services during the World War.

Minnesota State Medical Association.—The date of the annual meeting of the association in Minneapolis has been changed from October 3-5, to October 12-14, to avoid conflicting with the annual meeting of the Mississippi Valley Medical Association, which is scheduled to meet in Rochester, October 9-12, inclusive. This change will enable visiting physicians at Rochester to attend the state meeting at Minneapolis, the two days following.

MISSOURI

Salary of Medical Attaches.—The St. Louis Medical Society, June 6, authorized the appointment of a medical progress committee to survey the city health and hospital departments, in order to determine whether salaries paid to medical attaches are sufficient to insure the public the services of efficient men. A resolution for a survey was offered by the council of the society, in the belief that salaries are below those paid in other cities for similar service and by the United States government to employees of the U. S. Public Health Service.

Health Schools Planned.—One of a number of health schools to be conducted in various parts of the state, under the direction of the home demonstration agents and the extension department of the University of Missouri, was held at Independence, June 9. Instruction was given on how to make a hospital bed, how to bathe a patient in bed, how to change the bed clothing with patient in bed, morning and evening care, how to know general symptoms, how to take pulse, temperature and respiration, and how to treat bed sores. Persons taking the course, of whom there was a great number, will, on their return home, give the instruction they received to their respective communities.

MONTANA

Hospital News.—The contract has been let for the erection of the Barrett Hospital building, Dillon. The buildings will be completed in December.

Personal.—Dr. Francis S. Grey has been appointed health officer of Miles City.——Dr. Samuel E. Leard has been appointed health commissioner of Livingston.

NEW JERSEY

Chiropractor Fined.—It is reported that Meade Whiteside, a chiropractor, was fined $200 by Judge John A. Montgomery in Trenton, recently, for practicing without a license. Whiteside will appeal this decision.

NEW YORK

Anniversary of Charity Association.—The State Charities Aid Association of New York observed the fiftieth anniversary of its founding, May 11-12. The meetings were held at the Hotel Biltmore, New York, and included sessions on "County Programs for Child Care," "Child Placing and Mothers and Babies," and "Tuberculosis and Public Health: Retrospect and Outlook."

Technical Photographic and Microscopical Society.—This society was organized at a meeting held at the Chemists' Club, New York, May 10. It is planned to hold a general convention of industrial and microscopic photographers, in connection with an exhibition of photographic work, chemicals and apparatus which will be held during the national exposition of chemical industries in New York, September 11-16.

Labor Health Bureau.—At the annual convention of the Brotherhood of Painters, Paperhangers and Decorators of America, at Dallas, Texas, a resolution was adopted to form a health bureau for painters, "to save members of our hazardous trade from unnecessary death and suffering." Under the auspices of six of the larger painters' trade locals of New York, a workers' health bureau will be established in the city about July 1. Workers attending the proposed clinic will be given systematic health examination and care to guard against plumbism and other risks incidental to their occupation. After the movement has been instituted in New York, it is planned to extend the work to the entire metropolitan district.

New Hospital Regulations.—The board of health of the Department of Health of the City of New York at a meeting held, May 3, adopted the following resolution:

Resolved, That Section 220 of the Sanitary Code, be and the same is hereby amended and made to read as follows:

Section 220. Hospitals: permit required: exception.—No person, persons, or corporation, other than those specifically authorized by law, shall conduct or maintain a public or private hospital or institution, or advertise or hold out to the public that an establishment is conducted or maintained wherein human beings may be treated or cared for by physician or midwife, and no person, persons or corporation, other than those specifically authorized by law, shall conduct a lying-in hospital, home or place for the care of pregnant women or advertise, offer, or undertake to receive or care for them at such place, or at his or her home, without a permit therefor issued by the board of health or otherwise than in accordance with the terms of said permit, and with the regulations of said board.

Personal.—Drs. Elmer Ray Gladstone, Walton, Edward N. Packard, Saranac Lake, and Howard Goodrich, Delhi, have been appointed examining physicians under the New York State Veterans' Relief Commission.——Lieut.-Col. John M. Swan, Rochester, former commander of Base Hospital No. 19, has been awarded the conspicuous cross of the state of New York, following the citation of Dr. Swan by General Pershing in France, in April, 1919.——Lee K. Frankel sailed for Europe, June 20, as head of the executive committee of the American Jewish Relief Commission, to visit Jewish centers in order to determine the best way in which the $18,000,000 collected in this country may be spent.——Dr. Thomas Darlington, New York, was recently elected president of the American Association for Promoting Hygiene and Public Baths, at the annual meeting in Buffalo. Dr. Darlington succeeds the late Dr. Simon Baruch.

Prohibition Cuts Alcohol Death Rate.—The figures of the Bureau of Vital Statistics of the New York Health Department show that since prohibition went into effect decline in the alcoholic death rate has assumed extraordinary proportions. For comparison, it is considered fair to accept the year 1916 under the license system, since so many men were in military training and war activities in the two years following. In 1916, there were 690 deaths from alcohol in New York City; in 1920, 127 deaths, and in 1921, 141 deaths. This represents a decrease of 500 per cent. per annum. Life insurance figures show that, in 1917, the death rate due to alcoholism was 4.9 per hundred thousand policy holders, while in

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1921, the ratio was 0.9, or only one fifth the figure for 1917. Figures for 1921 show a decided decrease in deaths due to apoplexy, heart disease and chronic nephritis. The death rate of all three diseases was at a lower rate than in any wet year.

Hospital News.—Ground was broken recently for a new building at the Jamaica Hospital, Jamaica. The new building will be erected at a cost of $500,000 and will have accommodations for 123 patients.——All the buildings of the Fox Hills army hospital, Staten Island, were sold at auction recently. The ninety-one buildings which were constructed in 1918 at a cost of $2,500,000 were bid in for a total of $53,000 by various persons. The land on which the buildings stand is owned by the Travelers Insurance Company of Connecticut.——The Physician's Hospital Association of Plattsburg will build a $150,000 hospital building in the near future. A drive for funds will be conducted this summer.——Plans have been completed for the new laboratory building for Trudeau Sanatorium, Saranac Lake, to be erected at a cost of $95,000.——Mayor William Reynolds recently announced that he would provide a site for a new hospital at Long Beach. The sum of $30,000 has already been subscribed toward the building fund.——New York state will get three hospitals for the disabled ex-service men. One hospital will be erected at Liberty for tuberculous patients, and will have a 500 bed capacity. A 250 bed institution will be erected in the northern part of the state and another for tuberculous patients near Poughkeepsie.

NORTH CAROLINA

New County Health Officer.—Dr. J. H. Epperson, bacteriologist and chief inspector for the board of health, Durham, has been elected county health officer of Durham County, to succeed Dr. Archibald Cheatham, who resigned recently, owing to ill health.

NORTH DAKOTA

State Medical Meeting.—At the annual meeting of the North Dakota State Medical Association held in Jamestown, June 1-2, under the presidency of Dr. Harley E. French, University, the following officers were elected for the ensuing year: president, Dr. Eric P. Quain, Bismarck; president-elect, Dr. James Grassick, Grand Forks; first vice president, Dr. William C. Fawcett, Starkweather; second vice president, Dr. John H. Rindlaub; secretary, Dr. Hezekiah J. Rowe, Lisbon, and treasurer, Dr. William W. Wood, Jamestown. The next annual session will be held in Grand Forks.

OHIO

Goiter Clinic.—The first clinic devoted exclusively to goiter established in Dayton was opened, June 12, under the directions of Drs. Harry F. Patten and Robert C. Austin. This clinic will be open every Monday afternoon and service will be free to those unable to pay, while others will be referred to their family physicians.

New System at University.—Beginning June 19, the Ohio State University College of Medicine, Columbus, went under the four-quarter plan. By this system, the university will operate twelve months instead of nine months every year. There will be four quarters of eleven weeks each, to succeed the old plan of two semesters of four and one half months. The summer quarter will run from June 19 until September 2; the autumn quarter, from September 28 to December 22; the winter quarter, from January 2 to March 23, and the spring quarter from March 24 till June 8. By attending all sessions, it is possible for a student to earn a degree in three years instead of four. Regular courses leading to degrees will be offered in all except the professional colleges of law, medicine, dentistry, and pharmacy during the summer quarter of 1922. In only one respect does the summer quarter differ from the other three. It will be divided into two terms of equal length, extending from June 19 to July 26, and from July 27 to September 2. Students may enter for only one term and carry eight hours of work, or for the entire quarter, and schedule fifteen or sixteen hours.

OKLAHOMA

Privilege for Physicians.—Oklahoma City physicians have been granted exemption from certain traffic regulations, which will permit them to park in restricted zones.

Personal.—Dr. Andrew J. Smith has been appointed city and county health officer of Pawhuska, to succeed Dr. George W. Goss.——Dr. William W. Woody has been appointed full-time city health officer of Tulsa.

Hospital News.—The Marlow Hospital, Marlow, has recently been opened.——St. Anthony's Hospital Nurses' Home is under construction at Oklahoma City. The home will have a gymnasium, shower baths and a library, for the convenience of the inmates.——The new Methodist Hospital at Guthrie was formally opened, May 12. This structure, including the nurses' home, was erected at a cost of $52,000. Bishop Wardorf of Wichita, Kan., gave the opening address.

PENNSYLVANIA

Hospital Organization.—At a recent meeting of the ex-resident and resident physicians of the Wilkes-Barre City Hospital an association was formed with the following officers: president, Dr. George R. Drake, Plymouth; vice president, Dr. Charles Long, Wilkes-Barre; secretary, Dr. Harlem Irvin Evans, Ashley, and treasurer, Dr. Harry W. Croop, Kingston.

Pennsylvania Hospital Association.—At the annual meeting of the association in Harrisburg recently, Daniel T. Test, superintendent of the Pennsylvania Hospital, Philadelphia, was reelected president. Other officers elected were: Dr. Jonathan C. Biddle, Ashland, and Col. J. H. Bigger, Pittsburgh, vice presidents; Elmer E. Matthews, Wilkes-Barre, treasurer, and John M. Smith, Philadelphia, secretary.

Hospital News.—The new Intubation Hospital, Philadelphia, for children suffering from diphtheria, was recently opened. Dr. Chevalier Jackson will be chief consultant for the new hospital.——The Pennsylvania Hospital, which is a member of the welfare federation, in its annual report announced the handling of 23,751 accident and emergency cases during the year 1921. This is an average of one case every twenty-two minutes, or sixty-four a day.

Personal.—Dr. William Irwin, Philadelphia, sailed, June 24, for an extensive tour of Europe.——Dr. William H. Spencer has been appointed bronchoscopist to St. Agnes' Hospital, Philadelphia.——Drs. William E. Hughes and Robert N. Keeley, both of Philadelphia, recently left for the South Seas on a trip of pleasure and exploration.——Dr. George A. Piersol, emeritus professor of anatomy, University of Pennsylvania School of Medicine, Philadelphia, recently received the honorary degree of doctor of science, at the commencement exercises of the university.——Dr. Joseph Turner, formerly superintendent of the Eagleville Sanatorium, Eagleville, Pa., has been appointed second assistant director of Mount Sinai Hospital, New York.

Philadelphia

Philadelphia Laryngological Society.—At the annual meeting of the society, June 6, Dr. George W. MacKenzie was elected president; Dr. William A. Hitschler, vice president; Dr. Henry A. Leslie, reelected secretary, and Dr. Arthur J. Wagers was elected treasurer.

Portrait for University.—Memorial exercises were conducted by the University of Pennsylvania in the medical school, June 12, in honor of Dr. Howard M. Fussell, who died suddenly last October. A large portrait of Dr. Fussell, painted by Leopold Syffert, was presented to the university by members of the faculty of the medical school. The formal presentation address was given by Dr. David Reisman, a personal friend and former colleague. Acting Provost Josiah H. Penniman, in accepting the portrait for the university, paid high tribute to Dr. Fussell.

UTAH

Western Psychological Association.—The annual meeting of the association, which was to have been held at Salt Lake City, June 22-23, has been postponed. A meeting will probably be arranged at Stanford University later in the summer, it is announced.

TEXAS

University of Texas.—Expansion of the building facilities of the University of Texas, Galveston, to include the erection of a fireproof building for library and museum purposes at an approximate cost of $150,000, together with the construction of a frame building for laboratories at a cost of $12,500, and a central heating plant was announced, June 3, by Dr. William Keiller, acting dean of the college. During the absence of Dr. William S. Carter, dean of the college, in Manila, C. C. Gault, assistant in physiology at the University of

Minnesota, will be instructor in physiology. Drs. Joseph F. McVeigh and Dr. Mandred W. Comfort have been appointed adjunct professors in the department of anatomy and Drs. Proctor W. Day, John H. Wootters and Jesse B. Littlefield will be instructors in anatomy. These physicians are of the present graduating class. The newly created department of pharmacology will have Harry V. Atkinson, B.S., assistant in pharmacology and toxicology at the University of Illinois, in charge. Dr. Edward Randall, Sr., will be professor of therapeutics. Dr. Moise D. Levy has resigned from the department of medicine to practice in Houston; Dr. Joseph Kopecky will succeed him. Dr. George Townsend Lee, New York, has been appointed instructor in medicine. Drs. S. Gibbs Milliken and L. Terry, both of the present graduating class, will be the new instructors in pathology. Dr. O. Brown Williams has been appointed instructor in bacteriology and Dr. Frank W. Dimmitt, who had resigned his adjunct professorship in physiology to start practice in Galveston, will be instructor in dermatology and syphilology.

VIRGINIA

Hospital News.—Hill Top Sanatorium, Danville, was formally opened to the public, June 4.——Construction work has been started on the King's Mountain Memorial Hospital at Bristol. It is expected that the building will be finished in December. It will have sixty beds and three complete operating rooms. It is being erected at a cost of $150,000.

Personal.—Dr. William Armistead Gills, who has been attached to the United States naval station at Guam, has been ordered home. He will return to Richmond this month. ——Dr. William B. Porter, Stuart Circle Hospital, Richmond, has assumed charge of the medical department of the Lewis Gale Hospital, Roanoke.——Dr. Mary E. Brydon of the state board of health has been appointed by Governor Trinkle as one of the commissioners at large to investigate the feasibility of establishing separate schools for the deaf and blind. The report will be submitted to the next general assembly.

WISCONSIN

New Health Officer.—Dr. Gustaf R. Egeland has been appointed health officer of Sturgeon Bay, to succeed Dr. Thomas C. Proctor, who resigned following an injury to his eye.

Honorary Degree for Physician.—Dr. Thomas Hall Shastid, Superior, received the honorary degree of Doctor of Science at the recent commencement exercises of the University of Wisconsin.

CANADA

Nursing Centers.—On request of the Metropolitan Life Insurance Company of Sudbury and the citizens, a nursing service will be established there.——A training school for nurses will be established in connection with the Lady Minto Hospital, Cochrane.

National Council Meeting.—The annual meeting of the Ontario Branch of the Canadian National Council for Combating Venereal Diseases was held in London, May 12. Albert E. S. Smythe, Toronto, was elected president, and L. M. Wood, Toronto, treasurer.

Tuberculosis Clinics. — Four tuberculosis clinics were recently held at St. John, N. B., for the purpose of finding persons suffering from tuberculosis. The present difficulty is finding suitable treatment facilities for cases. Hundreds of people attended the clinics, many being turned away.

Academy of Medicine of Toronto.—At the annual meeting of the academy, the following officers were elected for the ensuing year: president, Dr. Wilbur H. Harris; vice president, Dr. John T. Fotheringham; honorary secretary, Dr. Frederick C. Harrison, and honorary treasurer, Dr. John H. McConnell.

Personal.—Dr. Edward L. Cash, formerly of Ottawa, has retired from active practice and is living on an orange ranch at Montebello, Calif.——Dr. David Dick has been appointed superintendent of the Hospital for Returned Soldiers, Red River, Alta.——Dr. John Henry Bell, Hamilton, has been appointed provincial medical examiner of the Royal Arcanum, Ontario, to succeed the late Dr. George Elliot of Toronto. ——Dr. Malcolm T. MacEachern, superintendent of the Vancouver General Hospital, B. C., has been appointed director-general of the Victorian Order of Nurses for Canada, and arrived in Ottawa in May to take up his new duties.——The Hon. John Michael Uhrich, M.D., has been appointed minister in charge of the bureau of public health for Saskatchewan. He also holds the portfolio of provincial secretary and is a member of the legislature.——President A. Blook, of the Canadian Association for the Prevention of Tuberculosis, has resigned to become sheriff at Regina, Sask., and has also accepted the appointment of superintendent and general manager of the Saskatchewan Sanatorium at Fort Qu'Appelle.

GENERAL

Gifts from World War Veterans.—It has been announced that a great number of the veterans of the World War are sending their checks for adjusted compensation back asking that the money be applied to the hospital fund for disabled soldiers.

American Otological Society.—At the annual meeting of the society in Washington, D. C., May 2-3, the following officers were elected: president, Dr. George E. Shambaugh, Chicago; vice president, Dr. John B. Rae, New York, and secretary-treasurer, Dr. Thomas J. Harris, New York.

American Orthopedic Association.—At the annual session in Washington, D. C., May 2-4, Dr. Ralph R. Fitch, Rochester, N. Y., was elected president of the association; Dr. W. S. Baer, Baltimore, was elected president-elect; Dr. Fred H. Albee, New York, vice president; Dr. John L. Porter, Chicago, secretary, and Dr. DeForest P. Willard, Philadelphia, secretary.

American Society for Clinical Investigation.—The annual meeting of the association was held in Washington, D. C., May 1. The following officers were elected for the ensuing year: president, Dr. Elliot P. Joslin, Boston; vice president, Dr. Charles F. Hoover, Cleveland; secretary, Dr. James H. Means, Boston, and treasurer, Dr. Ralph Pemberton, Philadelphia.

American Federation of Organizations for the Hard of Hearing.—At the third annual meeting of the federation in Toledo, June 12-14, under the presidency of Dr. Wendell C. Phillips, New York, the following officers were elected for the ensuing year: president, Dr. Harold A. Hayes, Buffalo; treasurer, Mrs. N. Todd Porter, Jr., and corresponding secretary, Miss Annetta W. Peck.

American Surgical Association.—At the annual meeting of this association in Washington, D. C., recently, Dr. Lewis L. McArthur, Chicago, was elected president; Drs. Ellsworth Eliot, Jr., New York, and Donald C. Balfour, Rochester, Minn., vice presidents; Dr. Robert B. Greenough, Boston, secretary, and Dr. Charles H. Peck, New York, treasurer. The next meeting of the association will be held in Rochester, Minn., in June, 1923.

Bills for Prohibition Department.—Two bills for the establishment of a separate bureau of prohibition under the authority of the President have been presented. In the Senate, the measure was introduced by Senator Ernst of Kentucky, and in the House by Representative Wood of Indiana. The purpose of the proposed legislation is to take the control of the enforcement of the prohibition laws from the jurisdiction of the Treasury Department and the Internal Revenue Bureau. Both bills went to the Committee on the Judiciary.

Charter for Siberian Veterans' Association.—A federal charter for the Siberian Veterans' Association is proposed in a bill introduced in the Senate by Senator Calder of New York at the request of the association's officers. The membership is to include those officers and men who served in Siberia during the World War. The organization, of which Brig.-Gen. W. S. Graves is commander-in-chief, claims a membership of approximately 2,500 and has established posts in nearly every state in the Union. More than 15,000 are eligible to membership.

Infantile Paralysis Study.—The Harvard Medical Commission, which instituted a five-year course of study into the causes and treatment of infantile paralysis, recently made a report of progress. The commission has about 2,000 actual cases under its supervision, while it is at the present time treating more than 1,000. The fundamental fact established is that infantile paralysis is not always or necessarily accompanied by paralysis. Practically 50 per cent. of the cases are not paralytic. It is estimated that there are 100,000 sufferers from the crippling effects of this disease in the United States today. The Harvard experts believe they have found a method of after-treatment for the disease, based on "muscle training," though, even under the most favorable conditions, progress is likely to be slow, it was stated.

Action on Tariff Bill.—The Senate this week adopted an amendment to the tariff bill which reduces the duty on surgical instruments, "composed wholly or in part of iron, steel, copper, brass, nickel, aluminum or other metal," to 45 per cent. ad valorem. This is the rate originally fixed in the bill as it passed the House of Representatives. The Senate committee subsequently advanced the rate to 60 per cent., which was considered excessively high; and much objection has been made to it. The rate of 45 per cent. is likely to stand in the final passage of the tariff bill. The Fordney bill as it now stands does not contain any provision whatever permitting the free importation without duty of philosophic, scientific and laboratory instruments, although the Payne-Aldrich bill, passed by a Republican Congress, and the Underwood bill, passed by a Democratic Congress, contained such provision. Unless educational institutions and persons interested in the restoration of this provision in the Fordney bill prevail on the Senate to amend the existing bill by the insertion of such a provision in the measure in the Senate, the subject cannot be adjusted by the Conference Committee.

Bequests and Donations.—The following bequests and donations have recently been announced:

New York Hospital Society, $500,000 in U. S. Victory Loan 3½ per cent. notes from George F. Baker, a governor of the society since 1899. The board, in accepting the gift, unanimously voted to establish the George F. Baker Endowment Fund of $750,000, consisting of the present donation of $500,000 and the $250,000 given to the society by Mr. Baker in 1912.

University of Virginia Medical School, $50,000, toward the erection of a new wing to the teaching hospital of the university, by Paul G. McIntire.

Mount Sinai Hospital, Philadelphia, $30,000, for the purpose of erecting a new building for the outpatient department, by Mr. William Lipkin of Philadelphia.

Albion, Mich., for a new hospital, $30,000, in memory of his grandfather, by James Sheldon Riley of Los Angeles.

North Side Day Nursery, Columbus, about $30,000 to the Columbus Nursing Association for a new modern home and hospital, by Mrs. W. A. Miller.

Grace Memorial Hospital, Banner Elk, N. C., about $20,000, by Mrs. Helen Hartly Jenkins of New York, in memory of her sister.

Home for the Friendless and the Old People's Home, Chicago, each, $10,000, by the will of Adolphus C. Bartlett of Chicago.

New York Association for the Blind, $5,000, and St. Giles Home for Crippled Children, $3,000, by the will of Miss Lucy Kirtland.

Johns Hopkins Hospital, Baltimore, $500, by the will of William H. Fischer, a tinner, and a former patient.

Sum Asked for Leprosarium.—In an estimate made by the director of the budget and submitted to Congress, it is recommended that the sum of $650,000 be appropriated for the coming fiscal year for the National Home of Lepers, controlled by the U. S. Public Health Service at Carville, La. The purpose of the appropriation is to provide for the care and treatment of persons afflicted with leprosy and to prevent the spread of leprosy. The budget director's communication reads in part as follows:

By the provisions of an act passed by Congress Feb. 3, 1917, Congress inaugurated a policy which contemplated the establishment of an institution to be operated by the U. S. Public Health Service for the care and treatment of all persons in the United States suffering with leprosy, including the necessary expenditures for transportation to this institution and their continued care therein. In puruance to this policy and under the legislation, there was purchased from the state of Louisiana an institution located at Carville, which had been used as a leprosarium by that state for many years, and with the expenditure of the funds available the bed capacity of this place was increased to 200. This place has now been in successful operation for a year or more, and is completely occupied. There do not exist any accurate figures as to the number of lepers within the United States. Estimates have been made which vary from 500 to 1,200 such persons. The experience of the U. S. Public Health Service since the opening of the leprosarium, however, leads to the belief that the higher is probably the more accurate figure. Insistent demands have been made on the Public Health Service ever since the opening of this institution. All facilities possible have been supplied with the existing appropriation and are employed to capacity. There still exists a waiting list from various states of the union, but further admissions cannot be made to this hospital until its facilities are expanded. Under the appropriation of $650,000 asked for, it is contemplated to increase the bed capacity of this place to a total of 500, and to supply an infirmary, quarters and other facilities necessary to the operation of the plant. The policy instituted by the national government was, of course, based on the possibility of eliminating the disease from the population of this country. There are good grounds for believing that if all persons suffering from leprosy are collected and segregated in the proper manner this disease may ultimately be eradicated completely. The present situation is pressing. The health authorities of the various states of the union, being in entire sympathy with the general policy of legislation, have at once proceeded to take advantage of the situation by attempting promptly to collect all lepers within their jurisdictions and to transfer them to the custody of the national government. The Public Health Service, however, as the agency of the national government, is without adequate facilities to meet these demands and will be unable to do so until sufficient funds are supplied for the extension of the plan as indicated.

The recommendation, on being received by Congress, was referred to the Committee on Appropriations of the House for action.

LATIN AMERICA

Colombian Hospitals.—A dispensary is being established on the first floor of the San Juan de Dios Hospital, Bogotá. ——The Surgical Society of Bogotá has been compelled, through lack of funds, to suspend work on the construction of San José Hospital.

International Infant Welfare Society.—A commission has been appointed by the Uruguayan government to prepare plans for the organization of the Pan-American Infant Welfare Office recommended by the second American congress on infant welfare. Dr. Luis Morquio will act as chairman of the commission, and Drs. J. A. Bauzá, P. de Peña, D. Regules, R. Schiaffino, V. Zerbino and R. Berro, as members.

New Central American Journal.—The undergraduates in the medical school at San Salvador have started the publication of a monthly, entitled *El Salvador Médico*. The publication is in charge of a board appointed by the society "Emilio Alvarez," which includes practically all medical students there in its membership of seventy-five. The leading article by Guillermo González is an attack on the increasing use of "patent medicines."

Leprosy.—According to a statement by Dr. H. C. de Souza Araujo, public health officer of the state of Para, Brazil, there are 1,135 cases of leprosy in the city of Para and 104 in the rest of the state. Of these, only 255 are segregated in the Yocunduba Leper Hospital.——The seventeen lepers segregated at Nigua, Santo Domingo, are being treated with chaulmoogra oil.——The government of Ecuador has asked its representative at Washington, D. C., to secure 8 liters of chaulmoogra to treat the lepers segregated at Pifo.

Personal.—Dr. Gutiérrez y Arango of Bogota has been elected president of the house of representatives of Colombia. ——Prof. F. Krause of Berlin, who is delivering a course of lectures on nerve surgery at the University of Rio de Janeiro, brought a formal greeting to the university from the German universities. The messages are written on parchment and are signed by the professors of the universities of Berlin, Leipzig, Rostock, Bonn, Halle, Heidelberg and Tübingen.—— The farewell banquet tendered Prof. Wilson Smillie, on his departure from S. Paulo for the United States, is said by the *Brazil-Medico* to have been brilliant and numerously attended.

FOREIGN

Portuguese Physician Honored.—Dr. Gomes Teixeira, who presided at the recent Spanish-Portuguese medical congress, has received an honorary degree from the University of Madrid.

British Institute of Physics.—At the annual meeting of the institute in London, May 23, the following officers were elected: president, Sir J. J. Thomson; vice presidents, Sir Charles Parsons, Prof. W. Eccles, Prof. C. H. Lees and Mr. C. C. Paterson.

Street Named for Local Health Officer.—The *Medicina Ibera* states that the people of Villamediana in Spain have recently changed the name of a street in honor of their *médico titular*, Dr. A. Mateo, as a tribute to his devoted services to the community.

Arsphenamin in Yaws. — Dr. Hata, Ehrlich's former co-worker, had occasion, in a recent visit to China, to observe the success of arsphenamin as used there in the treatment of frambesia. Professor Hata was so impressed as to write to Ehrlich's widow on the subject.

Medical Golfing Society.—The summer meeting of the Medical Golfing Society of England was held at Stoke Poges Golf Club, June 8. The *Lancet* challenge cup for best scratch return v. bogey; the Henry Morris challenge cup, and the society's gold medal for best return under handicap, were presented following the tournament.

Centennial of Mendel.—A Mendel festival was organized at Vienna by the Zoologic-Botanical Society to commemorate the hundredth anniversary of the birth of Gregor Johann Mendel, June 7, 1822, the Austrian priest, abbot of Brünn, whose experiments on garden peas revealed the now famous law of cross-bred inheritance. It was published in 1865.

Fire in Hospital at Rome.—The famous old Ospedale di Santo Spirito at Rome recently had a disastrous fire, destroying two pavilions with large loss of life in the incurable ward. The fire broke out at night, and several bodies were recovered in the morning. Many of the survivors were severely burned, in spite of the heroic efforts of the personnel and firemen.

Rovsing Festskrift.—Our Danish exchanges bring the account of the celebration at the Rigshospital at Copenhagen of Prof. T. Rovsing's sixtieth birthday. The speakers represented the leading medical organizations of Denmark, and they emphasized that from the first his scientific work has been fruitful in new points of view, from his very first work, on infection of the urinary passages. A souvenir volume was presented to him containing forty-six articles by his former pupils and assistants.

Tribute to Mangiagalli of Milan.—The celebration planned in honor of Professor Mangiagalli of Milan, Italy, has already been mentioned in these columns. The occasion was the completion of his fortieth year as professor of obstetrics and gynecology. He made the day memorable by his donation to the Maternity and to the Clinic for Occupational Diseases of funds to purchase the equipment for deep roentgenotherapy at the former and for general radiotherapy at the latter institution, the sum totaling 100,000 liras.

Centennial of Corti.—The *Klinische Wochenschrift* recalls that June 15 was the centennial of the birth, in Sardinia, of Alfonso Corti, who gave the world the perfect description of the internal ear. He studied at Paris and Vienna, where he was professor under Hyrtl, and in 1848 moved to Würzburg, where the results of his research on the organon spirale, called by Kölliker, the organ of Corti, were published in 1851. In 1855 he returned to Italy to live and abandoned further anatomic research, dying in 1876, aged 55.

Research on the Sexual Development of Children.—Our German exchanges mention that the Institute for Sexual Science in Berlin and the Institute for Experimental Pedagogics and Psychology at Leipzig have combined their efforts to study the physical and psychic development in the sexual sphere in children. They are appealing to parents, teachers, physicians and others to collect and send to them all kinds of data on this topic, personal observations, the questions asked, the confessions, the personal experiences, documents, diaries, poems and pictures by children, letters, models, etc. The data are to be sent to the Institut für experimentelle Pädogogik und Psychologie, Kramerstr. 411, Leipzig.

French Medical Congress.—Prof. Fernand Widal is to preside at the annual meeting of the Association of French Speaking Physicians, the Sixteenth French Medical Congress, which convenes at Paris, Oct. 12-14, 1922. The three subjects announced for discussion are "Elements for Differential Diagnosis of Gastric from Duodenal Ulcer"; "Pathologic Significance of Abnormal Shapes of Leukocytes," and "Prevention and Treatment of Deficiency Diseases." The addresses on the last mentioned subject are to be by Weill, Mouriquand and Rathery, who have done so much pioneer work in this line. The official notice of the congress states that physicians and other scientists who desire may take part in the congress subject to acceptance by the bureau; the fee is 45 francs. For further information apply to the permanent headquarters at the Faculté de Médecine, 12 Rue de l'Ecole de Médecine, Paris, which is also the permanent headquarters of the Association for the Development of Medical Relations with Foreign Countries. The secretary-general of the congress is Prof. A. Lemierre, 217 Rue du Faubourg-St.-Honoré, Paris.

Congresses to Be Held Abroad.—The eighteenth annual South African Medical Congress will be held, September 18-23, at Johannesburg.——The second annual meeting of the Medical Women's International Association will be held in Geneva, Switzerland, September 4-7, under the presidency of Dr. Esther Lovejoy, New York.——The first International Congress of Open-Air Schools will be held in Paris, June 24-28. Members' tickets are 20 francs.——An International Congress on Birth Control will be held in London, July 11-14. The congress will be devoted to the eugenic, economic, national and international, moral and religious, medical and contraceptive aspects of birth control. Fee for membership of the conference is about $2. Practitioners may become honorary members by applying to Dr. Dunlop, 71 Harley Street, London.——An International Congress for Health Education will take place in Paris, December 15-23. The object of the congress is to encourage the fight against venereal disease. The program will be divided into five parts: general hygiene, venereal disease, venereal prophylaxis, sex education, and measures to be taken. M. Emile Weisweiller, 7 Rue Mignon, Paris, is secretary general of the congress.

Poverty Among the Profession in Russia.—It is stated by the American Relief Administration that, at the University of Samara, Russia, 200 professors are working under distressing conditions. Living on a meager allowance of black flour and herring they have kept the university open, although they have had to spend time that might have been devoted to research work in outside employment, in order to earn enough food to keep their families alive. Many are ill, others in a weakened condition physically, as a result of overwork. Dr. Edmund A. Walsh, regent of the School of Foreign Service, Georgetown University, Washington, D. C., traveling in Russia for the National Catholic Welfare Council, writes that he found the wife of Bode, famous diagnostician, living with a family of five in two small, ill-lighted rooms. She was on the verge of starvation. He also states that, while he was in Moscow, the daughter of Mendeleieff, discoverer of the law for arriving at atomic weights of the basic elements, called on him and was desperately in need of food, though once very wealthy. Food packages will be distributed, purchased in large quantities through the Russian Food-Remittance Department of the American Relief Administration, among people not already included in relief programs, either because they do not live in the famine district or because they cannot properly be classified as acute starvation cases. This is the class of people that suffers most, seeking aid only at the last minute, with the result that many of them are in distressing circumstances.

The Antiarsphenamin Agitation in Germany.—The German lay papers have been inveighing against the use of arsphenamin, following the lead of Dreuw, who for years has been denouncing its use. The German Dermatological Society has been making a collective inquiry among its members as to whether they can subscribe to the following statement: "We are convinced that the arsphenamin preparations are the most valuable means at our command for combating syphilis as a disease of the individual and in the interests of the people as a whole. In the present stage of our knowledge they are remarkably effectual in all stages and forms of syphilis that are amenable to treatment, with few exceptions, and although they can be supplemented by the older remedies, the latter often are unable to take their place. If in the manufacture, testing and use of the arsphenamin preparations the indispensable care is maintained, the dangers with arsphenamin treatment are no greater than with every other energetically acting method of treatment. As these dangers have been recently presented in what in our opinion is an exaggerated form, we feel constrained to explain that arsphenamin treatment applied with caution and by experts cannot be restricted without great harm resulting for the public health in general." The members of the society were asked whether they had any essential objections to such an announcement and the *Wiener klinische Wochenschrift* relates that forty-three members said they disapproved of it, and fifteen said they had material reasons for not signing the circular, but 487 signed it, that is, 97 per cent. of the members.

Deaths in Other Countries

Dr. **John Cecil Carr,** superintendent of the Wilson Memorial Hospital, Pingyangfu, Shansi, China, at Shanghai, May 8, of heart disease.——Sir **Henry Davy,** president of the British Medical Association, 1907-1908, at Exeter, England.——Dr. **Robert Bruce Low,** epidemiologist and sanitarian; examiner in sanitary science, state medicine and public health for the universities of Edinburgh, Glasgow, Leeds and Cambridge; later inspector of examinations in the United Kingdom and Ireland; May 11, in London, aged 76.——**William D. Spanton,** former president of the British Gynecological Society and of the Staffordshire Branch of the British Medical Association, aged 81.——Dr. **E. Kalliontzis,** professor of surgery and topographic anatomy at the University of Athens. He was on various occasions the official representative of Greece in international gatherings.——Dr. **A. Gordon y Bermudes** of Havana, an officer of the national public health service.——Dr. **P. de Mattos,** of the Hospital Fernández of Buenos Aires.——Dr. **Fortineau,** professor of bacteriology at the University of Nantes, aged 40.——Dr. **P. Fabre** of Paris succumbed to fulminating scarlet fever, professionally acquired, aged 26.——Dr. **Van Bever** of Antwerp, chief of the service for the insane in Belgium.——Dr. **Renaud-Badet** of Paris.——Dr. **L. Rivata** of Busalla, Italy.——Dr. **G. J. Teljer,** a well known dermatologist of the Hague, aged 60.

Government Services

President Asks Appropriation for Public Health Service

The President of the United States has submitted a communication to Congress asking for an additional appropriation of $500,000 for the pay of personnel and the maintenance of hospitals by the U. S. Public Health Service. The communication contains a letter from the director of the budget, in which it is stated that the Public Health Service needs this additional sum for the fiscal year, 1923, in order to operate a hospital at Ellis Island for the care of immigrants coming into the United States. The Treasury Department, according to the budget authorities, is recompensed for this expenditure by the Bureau of Immigration. It is also pointed out that it is greatly to the interest of the government for the U. S. Public Health Service to operate this hospital rather than have it operated by the Department of Commerce, since the institution, when not actually used by sick immigrants, may be utilized by other patients of the Public Health Service. The President's communication has been referred to the Committee on Appropriations in the House.

Foreign Letters

LONDON

(From Our Regular Correspondent)

June 5, 1922.

The Increase of Cancer

The increase of cancer has again become a topic in the press. Sir William Veno, a layman, who has recently made a munificent benefaction for cancer research, points out in a letter to the *Times* how terrible a menace the disease has become to civilized society. In Great Britain, the victims to the disease number 40,000 annually, while in the United States they are more than double that number. In the quinquennial period 1912-1918 there were, in the registration countries of the world, one-half million deaths, or an average of 71.6 per hundred thousand of population. In Africa, the rate was 33.4; in Asia, 54.4; in Australasia, 73; in Europe, 76.6, and in America, 65.7. Thus, in the fully developed countries, or those in which the population is largely white, the death rates are highest. In Japan, up to comparatively recent times, the disease was almost unknown; but, since the country has been europeanized in customs and diet, cancer claims as many victims as in England. The very complete American statistics which are available show that Massachusetts tops the list, with a rate of 83.6 per hundred thousand. Rhode Island and New York come next, with rates of 82.7 and 80.4, respectively. At the bottom of the list are Montana and Kentucky, with rates of 53.7 and 48.3. Wherever the negro population is highest, the cancer death rate is lowest. Here again is evidence that the more highly civilized the population the higher the rate. What the exact cause of the increase is can only be a matter of speculation. Is it diet or manner of life?

Professor Joly of Trinity College, Dublin, in a letter to the *Times*, says that some years ago he was led to think that there is much in common between the reaction of the cell to radiative treatment and the behavior of those photosensitive substances which form the basis of photographic action. He infers that the increase in cancer may be due to such articles of diet as contain substances which have the properties of "sensitizers." Preeminent among these substances is tannin, which enters largely into the composition of tea and coffee. It is a fact that the mortality from cancer in recent years rose with tea consumption in this country. In the case of mouth cancer, which has been ascribed to tobacco smoking, powerful "sensitizers" are here again involved. In his recent Oliver-Sharpey lectures, delivered at the Royal College of Physicians, on "Common Defects of Diet," Dr. E. Mellanby also argued in favor of a dietetic origin of cancer. He stated that the Eskimos, before the introduction of modern diets, did not have cancer, and the same was true of the Icelanders. Only with the introduction of modern diets has cancer become common in Iceland, and it is now actually found among the Eskimos. Dr. Mellanby made an interesting comparison with rickets. Here were two condition both of which were diseases of growth—rickets and cancer. In one, there was certainly a relation to diet; while it was just possible that in the other there might be a similar relation.

International Congress of the History of Medicine

Arrangements are rapidly advancing for the third international congress of the history of medicine, which will open in London, July 17. Delegates are expected from a wide range of countries, including France, the United States, Belgium, Holland, Italy, Spain, Denmark, Norway and Czechoslovakia. The minister of health has accepted the committee's invitation to deliver the opening address. The program will include a reception by the lord mayor at the mansion house. Among the papers to be read is one on the "Early History of Anatomical Teaching at Edinburgh," by Dr. John D. Comrie, and one on the same subject concerning the United States, by Dr. Krumbaar of Philadelphia. Special interest attaches to a paper by Dr. Torkomian, an Armenian of Constantinople, which will deal with the Armenian history of inoculation against smallpox. Constantinople was the city from which the earliest of learned English "blue stockings," Lady Mary Wortley Montagu, in the early eighteenth century, derived the system of inoculation which she introduced into England, where it found great favor, until superseded by the jennerian system of vaccination. Visits will be paid to several places of great medicohistorical interest: the barbers' hall, the apothecaries' hall. A conversazione will be held at the Wellcome Historical Museum, and receptions will be held by the president of the Royal College of Surgeons at the college, and by the lord mayor at the mansion house. Those wishing to attend the congress should communicate with the general secretary, Dr. J. D. Rolleston, 21 Alexandra Mansions, King's Road, London, S.W. 3. The program gives a list of hotels with prices at which accommodation can be reserved if booked in time.

The Archives of Medical Hydrology

Under the title of the *Archives of Medical Hydrology*, the first number of a new periodical, which is the journal of the International Society of Medical Hydrology, has been published in London. In a foreword, Professor Carnot of Paris announces that the aim of the *Archives* is to compare and coordinate the research done on medicinal waters in the different countries, so as to draw conclusions which shall be useful to all, from the triple point of view of science, technic and therapeutics. Each nation possesses waters of individual character; comparison of their chemical constitution, physical composition and geologic character will permit us better to understand their nature and the character of their action. The *Archives* will enable us to compare the methods followed at the spas of different countries. From the therapeutic point of view, international exchanges respecting medicinal waters and climatic stations are desirable. International tours of medical study, like those already in vogue in France (voyages d'études médicales) should be organized in other countries. To the first number, Sir Clifford Allbutt contributes a learned preface on the use of waters for the preservation of health and the cure of disease. There is an article on "The Present State of Hydrology in the Countries Represented." The countries number ten, including America, Belgium, France, Great Britain, Holland, Italy, New Zealand, Scandinavia, Spain and Switzerland. It is noteworthy that the late enemy countries, Germany and Austria, are not represented.

The original papers are: "Some Physiological Effects of Exposure to Open Air and Water-Baths," by Prof. Leonard Hill; "The Scientific Foundations of Hydrotherapeutics," by Prof. Alois Strasser of Vienna (notwithstanding the fact that Austria is not among the countries represented); "The Treatment of Circulatory Trouble by Natural Effervescent Baths," by Dr. R. Wybauw of Brussels; "How to Study a Mineral Water at the Present Time," by Prof. A. Chassevant of Algiers and Dr. Ferrerolles of La Bourboule; "Modern Spectroscopy as Applied to the Study of Natural Mineral Waters," by S. Judd Lewis; "The Physiological Investigation of a Mineral Water, by Dr. William Bain, and "Stations thermales: traitement moderne du diabète," by Dr. Gustave Monod. A majority of the articles are in English and the remainder in French. Each is usually followed by a translation or abstract into the other language. The subscription to the journal is 10s. 6d. per annum ($2.50 at the par rate of exchange). Subscriptions should be sent to Headley Brothers, 18 Devonshire Street, Bishopsgate, London, E.C. 2.

The Treatment of Disease by Letter

Dr. Robert Bell, who is one of those practitioners who claim to cure cancer by medicinal means, was summoned before the general medical council for treating for nine months a woman suffering from inoperable cancer without having seen or examined her, such treatment having been carried out by correspondence with her husband, a person without medical skill or knowledge. Giving evidence, Dr. Bell stated that he was physican to the Women's Hospital, Glasgow, for twenty-one years, had practiced in London for twenty-one years, and was now superintendent for cancer research at the "Battersea General Anti-Vivisection Hospital." He produced a copy of a letter which he had sent to the patient's husband, asking for the cooperation of her physician, which was refused. If he had had the cooperation of the physician, the case would have had a different result (the patient died). He had cured four cases by correspondence in this manner. The chairman of the Battersea Hospital gave evidence that Dr. Bell had done "magnificent work" for the hospital, effecting some "wonderful cures."

The president of the council informed Dr. Bell that they could have judged him "guilty of infamous conduct in a professional respect," but they postponed pronouncing judgment until next year in order to have an opportunity of considering his conduct in the interval. They took a grave view of the conduct of a practitioner who treated a patient by correspondence without ever having seen or examined her, without having had any medical evidence as to the nature of her complaint and without securing any medical assistance or cooperation in the treatment. At the May session, 1924, of the council he must be prepared to satisfy them that his conduct in the interval had been without reproach, in respect to the methods which had been proved against him.

The Education of the Deaf Child

In an address delivered before the child study society and published in the *Lancet*, Mr. Macleod Yearsley, consulting aural surgeon to the London County Council, calls attention to the common disastrous mistake of regarding the deaf child as mentally defective. "Almost all deaf children," says Dr. Kerr Love, in his introduction to Miss Martin's excellent pamphlet "What the Mother of the Deaf Child Can Do," "are mentally sound, and this is especially true of deaf-born children." The deaf child is merely a normal child who has lost his most important educational sense. Whether he has been born without it or has lost it by disease after birth does not matter. The hearing child goes to school at 5 years with his physiologic education well under way; but, in England, the deaf child need not attend school until the age of 7, thus adding two years to his already severe handicap. In Scotland, deaf children must attend school at 5; in England, they are allowed to attend, provided the parents have paid grants for them. In Glasgow, they can attend at 3. Mr. Yearsley holds that, if we acted logically, the deaf child's education would begin at 3. But it may not be possible to send the child to school, and then, as Miss Martin has shown, the mother can successfully undertake the child's education. The home life is specially adapted for early training. But the ideal method is for the mother and the teacher to cooperate in training the child. Miss Martin's pamphlet should be in the hands of every one, mother, teacher or surgeon, who has to deal with the deaf child.

BELGIUM

(From Our Regular Correspondent)

LIÉGE, April 11, 1922.

Improvements in the Faculty of Medicine of Brussels

Thanks to the generosity of the Rockefeller Foundation, the Faculty of Medicine of Brussels will undergo some important transformations. Professor Depage intended to build a hospital and a school for nurses in Woluwe. The antiquated Saint-Pierre Hospital was no longer sufficient for clinical professors. An agreement was recently concluded between the Rockefeller Foundation, the city of Brussels and the Free University, and Professor Depage has abandoned his project in favor of a uniform program. It is now assured that Brussels will soon possess a modern medical equipment, which will be put at the disposal of the members of the faculty, and important progress in the teaching of medicine and in scientific research is expected.

Ophthalmology and Medical Studies

Now that all scientific societies are discussing new regulations to govern medical studies, the Belgian Society of Ophthalmology has expressed the wish that the resolutions quoted herewith concerning the study of ophthalmology be adopted: Members of the Belgian Society of Ophthalmology, after careful study of the report made by the committee appointed by the Royal Academy of Medicine to study reforms to be introduced in the curriculum of medical studies, believe that the importance of the ophthalmologic clinic should not be curtailed, for these reasons: 1. Cases of disease of the eyes are very frequent, always serious and often grave. 2. City practitioners can send their patients to specialists, while those who practice in the country or in small towns cannot do so, and they form the majority. It is of utmost importance that they acquire sufficient ophthalmologic knowledge, if serious consequences are to be prevented. 3. If we take into account that clinical and operative demonstrations are given only to a small number of pupils at a time, that students must be given individual attention in the various methods of examination, and that it would be a mistake to reduce the time devoted to clinical teaching, as clinical studies are the aim of all medical studies, we can conclude that the two years' study of this branch of medicine is not too much.

National League of Mental Hygiene

A new league, the National League of Mental Hygiene, which contemplates an important program, has just been definitely organized. Professor Ley bases his plan on similar organizations in other countries, especially those in the United States, and the Belgian league will try to carry it out successfully, with the help of consultations, dispensaries, schools, and welfare and benevolent societies. The work of the league will be divided into two sections, judicial and pedagogic, which will cover the problems of normal adults, social service and propaganda, military, industrial and professional, mental diseases, abnormal adults, abnormal children, toxicomania, delinquents and vagabonds.

Supernumerary Bones of the Foot

Drs. de Caestecker and de Nobele presented before the Society of Medicine of Ghent a complete and interesting study on supernumerary bones of the foot. They described the different varieties of supernumerary bones that can be encountered, and they showed how easily they may be confused with other affections, among which should be mentioned partial fractures of the bones of the foot or scaphoiditis in children. They make a differential diagnosis between these various affections, and they insist on the necessity of a bilateral roentgenographic examination, which is the only reliable means of diagnosis, as clinical symptoms have a very limited value. Their conclusions are of great importance from a medicolegal standpoint, especially in labor accidents. This is particularly true as regards the external tibial bone, which has nothing in common with the sesamoid or tendinous bones. It seems that these bones are a part of the skeleton, properly speaking, but that they have deviated from their primary direction by atavism.

Blood Transfusion in Illuminating Gas Poisoning

Dr. de Harven recently presented to the Société Clinique des Hôpitaux de Bruxelles an interesting case of carbon monoxid poisoning cured by blood transfusion. The patient was in a serious condition and the intoxication was characterized by convulsions occurring every ten minutes, superficial respiration, impalpable pulse, and hazy cornea. There was no resorption after injection of a considerable quantity of saline with epinephrin. Three hundred and fifty c.c. of blood was withdrawn from the radial artery and a transfusion of citrated blood was performed. The effect was excellent. The pulse became palpable; the arterial pressure rose, and the next day it was normal. The following day, the patient was conscious.

Medical Gatherings in Brussels

For the first time since last year, the Journées Médicales de Bruxelles will be held again under the management of the *Bruxelles Médical*. It has been found that practical work in hospitals and clinics, with expository lectures, is more useful and more interesting to practitioners than a congress in which discusssions often arise, without bearing fruit. This reunion will be held, June 25-28. The morning of June 25 will be devoted to the opening of the international exposition of surgical equipment, of instruments and pharmaceutic products, which will be followed by the inaugural session and a lecture. The mornings of June 26 and 27 will be devoted to demonstrations of operations in hospitals and clinics, inspection of medical and hygiene services in schools, and visits to institutes and laboratories. The afternoons will be devoted to lectures and motion pictures, which will be given more attention this year than last. June 28, there will be an excursion by train and motor to Belgian health resorts. Besides the scientific work, there will be many and various forms of recreation for physicians and their wives.

BERLIN

(From Our Regular Correspondent)

May 27, 1922.

Medical Congresses

During the Easter vacation period, a congress of the German executive committee for the investigation and control of cancer disease, another of the German roentgenographic society and the congress for diseases of nutrition and metabolism were held. At the cancer congress, Caspari reported the results of his researches on the cancer problem, especially from the standpoint of immunity. He stated that experimental animal cancers are, in a way, analogous to spontaneous cancers in man, but that the different origin of the two kinds of cancer must be kept in mind. Whereas a spontaneous cancer springs from a single group of cells or from several groups, and, in fact, may originate from a single cell, in the artificial transmission by inoculation the experimental animal is permeated with cancer tissue. But most of this cancerous material becomes necrotic, so that only certain small cell groups develop and form the tumor.

Caspari has been conducting researches on the significance of the necrotic substance, and has reached the conclusion that it exerts four different effects. Through chemotactic stimulation of the connective tissue of the animal it causes the formation of the capsule and stroma, and thus provides, indirectly, for the formation of the blood vessels that are necessary for the blood supply to the tumor. It serves, furthermore, as adequate sustenance to the developing tumor cells, exerts a toxic effect and calls forth a general immunity reaction on the part of the organism. Recent researches indicate that, with the decomposition of the cells, hormone-like substances arise, which, through their action on the whole organism, raise the level of immunity. It is a question of nonspecific immunity such as has already been shown to exist in numerous infectious diseases. Aside from this nonspecific immunity, there are some indications of a specific immunity. Caspari found that the serum of rabbits that have been inoculated with mouse tumor has an increased toxic effect on mice of all kinds, except such as are suffering from sarcoma. From this fact, Caspari concludes that the mice last mentioned were protected against sarcoma by specific antibodies.

Manninger, from Pest, reported on the excision of cancer by means of a cautery—so-called igniexcision. This method has proved efficacious in his hands not only for the removal of the primary tumor but also for the destruction of involved glands. The course of the operation is not essentially different from other operations. The vessels are divided between two clamps with a Paquelin cautery. The course of healing is smoother than in ordinary operations. Postoperative hemorrhages were observed in only two cases. Of ninety-eight patients operated on between 1900 and 1916, forty-one are still living. According to the report of the director of the Sauerbruch Clinic in Munich, Dr. G. Schmidt has been using, for some time, a similar procedure. It has created a favorable impression there, as well. The wounds become quickly sterile, and the patients recover rapidly. The cautery was employed only when a surgical operation seemed contraindicated. Von Eiselsberg is inclined to use this procedure in cancer of the abdomen, and he also is satisfied with the results.

Küttner reported to the surgical congress the results that he has achieved in the surgical treatment of sarcoma. According to his experiences, operation is superior to roentgen irradiation. Of his 740 patients, one patient is living seventeen years after the operation. During the first year after operation, 45.5 per cent. of the patients died (39.9 per cent. from sarcoma of the bone, and 49.5 per cent. from sarcoma of the soft parts); 14.8 per cent. died during the second or third year after operation (bone sarcomas, 15.2 per cent.; sarcoma of the soft parts, 14.6 per cent.); in the fourth or fifth year, 5.3 per cent. (bone sarcomas, 3.3 per cent.; sarcoma of the soft parts, 6.5 per cent.). Of 326 cures, ninety-four proved to be permanent, as compared with which there have been only from 32 to 36 per cent. of "three-year cures" reported by roentgenologists. Sarcomas may be divided into three classes: (1) those that should by all means be irradiated; (2) those that should be operated on without fail, and (3) those that should be operated on only under certain conditions. To the first group belong the inoperable sarcomas, sarcomas of the lymph glands and those of the thyroid.

To the second group belong all sarcomas, except the aforementioned, which, without danger to the patient, may probably be removed radically. As in carcinoma, the regional lymph glands should be removed in every sarcoma operation. To the third group belong the sarcomas that may not be removed radically, either on account of the site of the tumor, or on account of the extent of the mutilation that would result.

Anschütz found that, of 239 patients operated on for sarcoma, thirty-nine survived for more than three years. Of 174 peripheral (periosteal) bone sarcomas, a cure was effected in 9 per cent.; of sixty-five centrally located (myelogenous) sarcomas, a cure was brought about in 24 per cent. An especially good prognosis is furnished by the giant cell sarcomas, but some of them are not in reality sarcomas but ostitis fibrosa. Among the cases of sarcoma in which a cure was effected, there is one of sarcoma of the thyroid in which there has been no recurrence after four years.

Death of Leube and Quincke

Leube and Quincke, two clinicians of the previous generation, died within a few days of each other, both shortly before the completion of their seventy-ninth year, and both retaining up to the time of their death rare physical energy and mental vigor.

Leube, who died May 16 in a small health resort, had acquired fame chiefly in the field of gastro-intestinal pathology. As a pupil of von Ziemssen, he was a prominent representative of the hippocratic school and one who did not confine himself to conclusions based on the results of laboratory tests but always considered the patient. About ten years ago, Leube gave up his university position. Aside from participation in the social welfare movement for the control of tuberculosis, he had had scarcely anything to do with medicine since his retirement, devoting his time exclusively to studies on the history of art.

Quincke devoted himself to medical research almost until his last breath, and often contributed articles on the leading questions of the day. Among his most significant contributions to medical science, I may mention articles on acute circumscribed edema, meningitis serosa, pneumotomy, diseases of the liver, and, above all, lumbar puncture. He wrote also numerous articles on general questions of pathology, such as pathology of the heart, of the nervous system and of the kidneys.

VIENNA

(From Our Regular Correspondent)

May 13, 1922.

Proposed New Subject for the Medical Curriculum and Higher Schools

During the last three years, sweeping measures have been adopted in this country as regards social medicine and social insurance. The work entailed in the classification and estimation of the war injuries requires a great amount of special knowledge, and the majority of physicians on whom the burden of this was chiefly thrown were not well instructed along these lines. With the increase and spread of social provisional work and social insurance, and as more and more of the population are coming under its working, the adequate instruction of the physicians entrusted with this task is paramount. Therefore, it will be necessary to enable the more advanced students to gain that knowledge which the fully qualified physician requires, if he is called on to help in social work. Special courses dealing with the hygienics of industrial work, calculation of degree of disablement, and child and mother welfare centers will be instituted, and both theoretical and practical knowledge will thus be obtainable for all desiring it. The officials also who are engaged in this kind of administrative work shall be bound to enter these classes, preferably before entering the state service. Therefore, in all higher public schools—aside from the elementary schools—lectures on these subjects should be offered, while yearly graduate classes should be conducted for those who are already working under the social insurance acts. These were the chief points of a report recently made to the government by a committee of members of the national assembly, which is now being considered by a special committee of the House.

Welfare Centers of the American Red Cross in Austria for Infants and Young Children

The American Red Cross in Vienna has undertaken the task of organizing and developing plans for the welfare of infants in this country, along uniform and up-to-date lines. It became evident that all the charitable institutions dealing with this kind of work must be merged into one body, and that competent co-workers were necessary. The officials of the board of health and the state and district corporations, as well as the private welfare centers, were soon united, and their working staff was taken over by the American Red Cross. With the aid of the leading men in Austria, Professor Moll, Dr. Dehne, Dr. Koch and Dr. Pörner, a network of welfare centers, numbering ninety-nine stations all over the country, was established.

A number of fully qualified physicians and trained nurses were appointed for these stations. It was rather difficult, however, to find the necessary men for the country districts. Therefore, the American Red Cross has instituted a series of special classes in Vienna, chiefly for the benefit of the physicians entrusted with the care of the rural stations, where they are taught all that is required for dealing with the baby stations. The necessary number of trained nurses was not forthcoming; for these also a number of special courses had to be instituted, comprising three months of theoretical and six weeks of practical instruction in the Central Infant Station of Vienna. "Perfection classes" are being held now and then for the nurses in several country towns, and each group of nurses in turn is called on to attend them. The sites for the welfare centers were provided by the communities and municipalities, as well as fuel and lighting, while the equipment, instruments and apparatus were provided by the American Red Cross.

The chief factors in the work of these centers are these: Care is taken of the children from their birth until they complete their sixth year. Attention is focused on the infant in the first year of life, while the prospective mother is also looked after during pregnancy. Prophylaxis is the leading idea, and premiums are not given, for the mothers are to be educated to look on welfare care, of itself, as the thing aimed at. Only the healthy child is given the care of the centers, but close touch is maintained with physicians and hospitals, lest a pathologic condition threaten. An important feature of the plan is the visiting nurse or health visitor. Each center comprises one or two such visitors, besides the physicians and his assistants.

The American Red Cross intends to give in Baden (near Vienna) a "health demonstration," as it is termed in the United States; it will provide all children up to two years with special care, and will assist them and their mothers with milk, additional food and health premiums, thus demonstrating the value of this work for public health, and chiefly for the decrease of infant mortality. A journal of the American Red Cross published at regular intervals serves as an intermediary instrument for rapid dissemination of information to all cooperators. Thus, by means of funds granted by the American Red Cross and by aid from other sources, a lasting impression on the race may be made.

V. 7
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Old Age Provisions for Medical Men

With the exception of the small percentage of medical men who are engaged by the state or by large corporations, and who receive substantial pay with the right to corresponding pension on retirement or old age, the majority of our physicians are at present absolutely helpless, if, for some cause or other, they can no longer continue their practice. All insurance policies taken out in peace time for sums deemed then sufficiently high are now simply worthless, as they are paid out in a currency having a buying capacity nearly nil. The majority of pensions payable on the present scale of salaries, to which the physicians of the Krankenkasse or the state appointments are entitled, are also very meager, barely sufficient to maintain life.

Only a few physicians are well situated financially, and able to live on their private means. Therefore, the problem of providing for the old or invalid practitioner or for his family, in the event of his death, has become a vital one. Self-help is the only possible means, and the profession has now taken up the matter. The organization of Vienna practitioners has instructed a special committee to study the question and suggest a suitable method of handling the problem. The following plan, similar to one which is employed in several institutions of a private nature, has been recommended and will no doubt be adopted: Every member of the profession, private practitioners and hospital physicians, or men under service in corporations not guaranteeing an adequate old-age pension, shall, by law, be bound to become members of a mutual insurance institute. In case a member dies or reaches a certain age limit (from 65 to 70 years), or is invalided, all other members have to contribute a certain modest sum—say, 500 kronen. This would mean that in such an event a sum of over-three million kronen would be available at once for the physician or his family, as we have over 6,000 practitioners here. Such a sum is, even at our present rate of currency, quite a handsome one, enough to keep a family going for more than a year, or to enable them to become self-supporting. In addition to these contributions by the practitioners, it is intended to raise very considerable sums for the same purpose by a tax of from 1 to 2 per cent. on each prescription, by contribution from the "Bundeskrankenkasse" (the sickness club, with free choice of physicians) of 1 per cent. deducted from the fees paid to physicians, and by a similar tax of 1 per cent. on all bills paid in nursing homes and sanatoriums. It has been calculated that at least thirty million kronen could be obtained within one year, and probably much more. It would thus be possible either to increase substantially the sum payable in each case or to diminish the contributions payable by each member of the institute.

The foregoing plan, roughly sketched, is only one of several offered for consideration, but is the one most likely to be adopted. It has been thought unwise to provide for yearly or monthly pensions, since, owing to the violent fluctuations of the currency value, no fixed relation between premiums and pensions is possible, and a substantial sum granted at once serves best the purpose aimed at.

Decrease of Midwifery Cases in Private Practice

Both general practitioners and midwives are complaining that the number of pregnant women who are cared for at home during labor is constantly diminishing. They, as a rule, prefer nowadays to arrange for their confinement in one of the public institutes, where the house physician and the midwife are not able to assist at the birth of the child. It is true that the present domestic or, rather, housing difficulties makes it preferable to deliver a woman in a well equipped hospital rather than in the ill-ventilated, narrow or overcrowded flat or bedroom, which is only too often also the sitting and dining room and nursery, all in one.

In order to counteract the deleterious effect of these conditions on the financial situation of the general practitioner, endeavors are being made to arrange, in all public hospitals and gynecologic clinics, that private patients be admitted under the care of their own physician or their own midwife, at moderate rates. This would not only tend to lessen the deficit of the hospitals, as these patients would, of course, have to pay more than is paid for the ordinary hospital patients by the state, but would also gradually settle the problem of the "sanatorium for the middle classes" which for a long time has been puzzling all concerned. The wealthy classes can avail themselves of the first class confinement homes and sanatoriums, and for the poor people we have excellently equipped hospitals, clinics and wards; but the middle classes were and are worse off, just as in every other respect.

Vital Statistics for 1921

The statistic department of the ministry of health has published a few data referring to the fluctuations of the population in Austria last year which give a very interesting insight into the slow but constant improvement in the general health conditions of this country. Thus, the number of marriages has increased by 6,166, the total being 83,575. Of course, the greatest number took place in Vienna, viz., 31,164, or 4,982 more than the year before; 142,133 children were born, while 117,023 persons died. Among the latter figures, we find in the whole country 4,351 cases of stillbirth and 21,701 children under 12 months. Deplorable as these figures are, they nevertheless show that the mortality of children over 1 year of age is markedly less, because of the greater care bestowed on them by the welfare centers, just as in the case of older persons, who are also looked after in a more effective way.

As regards the causes of death, we find a distinct drop in tuberculosis, whooping cough, dysentery and organic heart disease, as causes of death, while measles, pneumonia, cholera infantum (due to the hot summer) and infectious diseases claimed more victims than last year. There died in Vienna alone 33,672 persons, while only in two provinces was the number of deaths higher than last year (in Upper Austria and the Tyrol).

Marriages

HENRY RICHMOND SLACK, JR., Baltimore, to Miss Elizabeth Blanchard Randall, at Catonsville, Md., June 14.

JOHN MINOR, Washington, D. C., to Miss Mildred Angevine Truslow of Summit, N. J., April 22.

SAMUEL B. BARISHAW, Jersey City, N. J., to Miss Rena R. Harris of Newark, N. J., April 6.

PAUL FORREY STOOKEY, Kansas City, Mo., to Miss Clara Sachse, at Kansas City, recently.

WILLIAM EDGAR MATTHEWS to Miss Eva Mildred Waters, both of Johnstown, Pa., June 11.

MARTIN ROBERT LORENZEN, Curtice, Ohio, to Miss Pearl A. Bush of Howell, Mich., June 10.

UREY GUESS DAVIS to Miss Emma Cooke Pickering, both of Hopkinsville, Ky., June 14.

BERNARD JOHN MCCORMICK to Miss Cecelia Virginia Lee, both of Pittsburgh, May 10.

EDWIN LOUIS FREDERICK to Miss Bertha D'Unger, both of Catonsville, Md., June 7.

LEON E. SEVEY to Miss L. May Glover, both of Grand Rapids, Mich., May 20.

ALBERT STEIN, Springfield, Mass., to Miss Ida Tobackman, at Springfield, June 4.

HERBERT N. MCCOY to Mrs. Ethel M. Terry, both of Chicago, June 13.

Deaths

Crawford Lester Hall ● Kansas City, Mo.; Jefferson Medical College, Philadelphia, 1867; professor of diseases of women, and president of the board of directors of the Medical Chirurgical College of Kansas City; professor of diseases of women, Kansas City Postgraduate Medical School and Hospital; at one time professor of gynecology at the University of Kansas School of Medicine, Rosedale, Kan.; member of the Western Surgical and Gynecological Association; president of the Missouri State Medical Association, 1895-1896; served as president of the Kansas City Academy of Medicine, 1893; secretary of the Section of Obstetrics and Gynecology of the American Medical Association, 1897-1898; died at his home, June 10, aged 76, from cerebral hemorrhage.

Winifred Estelle Thomas Heston, East Jordon, Mich.; Laura Memorial Woman's Medical College, Cincinnati, 1901; associate physician at the General Hospital, Miraj, India, 1903-1907; later in general practice at Kohlapur, and in charge of the Good Samaritan Hospital, Jhelum; author of "A Blue Stocking in India," 1910; died, recently, from an overdose of an opiate, taken accidentally, following a long illness, at East Jordan, aged 49.

Russel Herbert Boggs ● Pittsburgh; Western Pennsylvania Medical College, Pittsburgh, 1897; member of the American Roentgen Ray Society, and the New York Roentgen Ray Society; formerly radiographer at the Allegheny General Hospital and professor of radiography and phototherapy, Western Pennsylvania Medical College and Pittsburgh Dental College; died, June 2, aged 47.

Frederick Kellum Blair, Morehead, Ky.; University of Louisville Medical Department, Louisville, 1914; member of the Kentucky State Medical Association; served in France, M. C., U. S. Army, with the rank of lieutenant; died, June 1, at the St. Anthony's Hospital, Louisville, aged 32, from a valvular lesion of the heart.

Sampy Davis Hatfield ● Kokomo, Ind.; Louisville Medical College, Louisville, 1906; died, June 2, aged 41, at the Good Samaritan Hospital, from a bullet wound through the abdomen, received in his office when the revolver of Patrolman Randall of the Kokomo police force dropped to the floor and exploded accidentally.

Rollo Howard Hoey, Easton, Pa.; University of Pennsylvania School of Medicine, Philadelphia, 1909; member of the Medical Society of the State of Pennsylvania; served in the M. C., U. S. Army, during the World War; died, May 23, aged 36, at Morristown, N. J., from cardiorenal disease.

Oliver George Wintera, Des Moines, Iowa; Bellevue Hospital Medical College, New York, 1888; formerly city physician, member of the city council and school board of La Crosse, Wis.; member of the Iowa State Medical Society; died, June 4, aged 63.

Richard Proctor Huger, Anniston, Ala.; Medical College of the State of South Carolina, Charleston, 1871; member of the Medical Association of the State of Alabama; formerly mayor of Anniston; died suddenly, June 3, aged 72, from heart disease.

Henry F. Scott, Atlanta, Ga.; Atlanta Medical College, Atlanta, Ga., 1874; for thirty years secretary to the Central Bank Block Association; formerly demonstrator of anatomy at the Atlanta Medical College; died, May 17, aged 69, from heart disease.

Abner Byron Bailey, Fennimore, Wis.; Bennett College of Eclectic Medicine and Surgery, Chicago, 1889; for several years a member of the state board of medical examiners, and president of Fennimore Village; died, May 23, aged 71, from paresis.

Frederick V. Matlock ● Salem, Ky.; Hospital College of Medicine, Medical Department, Central University of Kentucky, Louisville, 1907; died, May 10, aged 55, at the Riverside Hospital, Paducah, from chronic interstitial nephritis.

Ernest H. Wiedrich, Newark, N. Y.; Syracuse University College of Medicine, Syracuse, 1908; member of the Medical Society of the State of New York; died, May 24, aged 36, at the home of his father in Bergen.

Emmett James Hinton, Wrightsboro, Texas; Medical Department, University of Tennessee, Memphis, 1904; member of the State Medical Association of Texas; died, May 13, aged 40, from chronic nephritis.

Jonathan Larkin Forward ● Chester, Pa.; University of Pennsylvania School of Medicine, Philadelphia, 1857; for several years mayor of Chester; chief of staff at the Chester Hospital; died, June 7, aged 90.

William A. Justice, Greenfield, Ind.; Kentucky School of Medicine, Louisville, 1878; member of the Indiana State Medical Association; formerly county coroner; died, June 6, aged 63, from cerebral hemorrhage.

Helen McNicholl English, Seaside Heights, N. J.; Woman's Medical College of Pennsylvania, Philadelphia, 1906; hanged herself, June 7, at the home of a friend in Burlington, while temporarily insane, aged 38.

John H. Stuckey, Rosenberg, Texas; Memphis Hospital Medical College, Memphis, 1901; member of the State Medical Association of Texas; died, May 12, aged 49, at Sanatorium, from tuberculosis.

George Newlands ● Seattle; Queen's University Faculty of Medicine, Kingston, Ont., Canada, 1879; died, May 1, aged 70, at the Providence City Hospital, Seattle, from meningitis.

David F. Unger, Mercersburg, Pa.; Bellevue Hospital Medical College, New York, 1869; member of the Medical Society of the State of Pennsylvania; Civil War veteran; died, June 2, aged 78.

Oliver P. Norris, Waltonville, Ill.; Cincinnati College of Medicine and Surgery, Cincinnati, 1871; president of the Waltonville State Bank; Civil War veteran; died, June 1, aged 78.

Winfield S. Ferguson, Kansas City, Kan. (licensed, Kansas, 1892); also a veterinarian; was found dead, June 6, with a bullet wound through his head, presumably self-inflicted, aged 61.

Henry Calhoun Fleming ● Denison, Texas; Louisville Medical College, Louisville, Ky., 1889; died, April 26, aged 69, at Henderson, Ky., from dilatation of heart.

George William Lane, Corning, N. Y.; University of Buffalo Department of Medicine, Buffalo, 1886; for several years mayor of Corning; died, May 24, aged 64.

Byron Garrett Van Horne ● Englewood, N. J.; University of Pennsylvania School of Medicine, Philadelphia, 1896; died, May 20, aged 64, from cerebral hemorrhage.

Herbert S. Sleeper ● Lewiston, Me.; University of Vermont College of Medicine, Burlington, Vt., 1891; died in May, aged 66, from angina pectoris.

John L. Kennard, Morrisville, Mo.; Medical College of Ohio, Cincinnati, 1878; died, May 17, at Fredonia, Kan., aged 68, from cerebral hemorrhage.

Edward W. Paul, Forest City, Ill.; Rush Medical College, Chicago, 1884; member of the Illinois State Medical Society; died, May 26, aged 66.

Elsey V. B. Buckingham, Willard, Ohio; Miami Medical College, Cincinnati, 1872; died, June 5, aged 81, from carcinoma of the stomach.

James W. Mills, Atlanta, Ga.; Georgia College of Eclectic Medicine and Surgery, Atlanta, 1897; Confederate veteran; died, June 2, aged 89.

Salmon Giddings Howd ● Winsted, Conn.; Jefferson Medical College, Philadelphia, 1883; died, May 10, aged 64, from interstitial nephritis.

William H. Palmer, Blair, Neb.; Rush Medical College, Chicago, 1870; Civil War veteran; was found dead in bed, June 2, aged 83.

John William Lilly, Toledo, Ohio; Starling Medical College, Columbus, Ohio, 1882; died, May 25, aged 65, from mitral stenosis.

Robert Furman Adams, Syracuse, N. Y.; Chicago Homeopathic Medical College, 1880; died, April 18, aged 74, from pneumonia.

Katherine B. Clapp, Chicago; Hahnemann Medical College and Hospital, Chicago, 1894; died, June 12, aged 71, from carcinoma.

Thaddeus N. Kabler, Bedford Springs, Va. (years of practice); died, April 28, aged 94, following fracture of the femur.

Charles Snyder, London, Ohio; Medical College of Ohio, Cincinnati, 1870; died, June 1, aged 73, from paresis.

Oscar J. R. Hanna, Jackson, Mich. (licensed, Michigan, 1900); died, June 2, aged 75, from heart disease.

James King, Leamington, Ont. (licensed, Ontario, 1893); died, March 24, aged 53.

● Indicates "Fellow" of the American Medical Association.

V. 7
1922

Correspondence

"BLUISH DISCOLORATION OF THE UMBILICUS"

To the Editor:—About a week after the appearance of Dr. Novak's article on bluish discoloration of the umbilicus in the diagnosis of ruptured extra-uterine pregnancy (THE JOURNAL, March 4, 1922, p. 643) I was examining a tertipara who had come to me about a month earlier, and was surprised to find that a marked bluishness had developed below the umbilicus, in the interval. It was, if anything, even deeper in hue than that shown in the illustration. She was at that time in the beginning of the seventh month of pregnancy and had absolutely no evidence of anything abnormal in the pelvis or abdomen.

She progressed satisfactorily with her pregnancy and was delivered of a normal 6¾ pound (3 kg.) boy, after being in labor a little less than three hours, May 31.

During the last three weeks of pregnancy the discoloration gradually faded and had almost entirely disappeared at the time of delivery.

From this case it can be seen that the sign is not particularly reliable as evidence of ruptured tubes or uterus, when it appears late in pregnancy.

F. H. STIBBENS, M.D., Oakland, Calif.

"PHYSICAL EXAMINATION OF FOOD HANDLERS"

To the Editor:—My reaction to the article of Dr. L. B. Gloyne on the physical examination of food handlers was similar to that of Col. P. M. Ashburn, whose letter appears in THE JOURNAL, June 3, and I feel that this point is of sufficient importance to be further emphasized.

In an experience of fifteen years, I do not recall a single case of accidental infection of either syphilis or gonorrhea, except in professional people, namely, nurses or physicians. I feel, therefore, that much of the propaganda emphasizing the dangers of accidental infection is greatly exaggerated and without real point. The law in Minnesota formerly removed automatically any venereally diseased person from an occupation of food handling of any kind. Realizing the injustice of this, changes were made in it in 1921 in order that it might be applied only in specific instances in which there seemed a real reason for temporarily removing the person from his occupation. This law is at present enforced by the food and dairy commissioner, but it will be noted that on discovery of such diseased persons, they are removed from their occupation only while the state board of health is making an investigation, and that their permanent removal depends entirely on valid reasons, as indicated by investigation of that board.

This section of our law reads:

Chapter 495, Section 45. Employment of diseased person.—It shall be unlawful for any person to work in or about any place where any fruit or any food products are manufactured, packed, stored, deposited, collected, prepared, produced or sold, any person or persons whose condition is such that disease may be spread to his associates direct, or through the medium of milk, cream, butter, other food or food products, likely to be eaten without being cooked after handling, whether such condition be due to a contagious, infectious or venereal disease, in its active or convalescent stages, or to the presence of disease germs, whether accompanied by, or without, any symptoms of the disease itself.

It shall be the duty of the state dairy and food commissioner, his assistants, inspectors or agents, to report to the state board of health for investigation any person suspected to be dangerous to the public health as provided for in this section, and immediately to exclude such person from such employment pending investigation and during the period of infectiousness, if such person is certified by the state board of health or its authorized agent to be dangerous to the public health.

It may not be esthetic to have persons venereally diseased handling food. On the other hand, with anything but the exceptional case of syphilis with very marked infectious skin lesions, it is certainly silly to keep a man away from his legitimate occupation for weeks or months at a time.

H. G. IRVINE, M.D., Minneapolis.
Director, Division of Venereal Diseases,
Minnesota State Board of Health.

"THE PROPHYLAXIS OF VENEREAL DISEASE"

To the Editor:—The accompanying notes and figures appeal to me as being worthy of publication at this time as a complement to those by Dr. Walker (THE JOURNAL, May 20, 1922, p. 1510). One should also keep in mind that chemical prophylaxis is not applicable to women. Among a large group of adult males, with facilities for chemical prophylaxis at hand, and with punishment for failure to use prophylaxis if they became diseased, our figures definitely show that the more prophylactics administered, that is, the more admitted exposures, the greater the incidence of venereal disease. On the other hand, when opportunity for prophylaxis was reduced by curtailment of opportunity of exposures, the incidence of venereal disease became practically nil. That chemical prophylaxis alone will ultimately bring realization of the abolition of venereal disease is still far fetched.

TABLE 1.—CHEMICAL PROPHYLAXIS AND VENEREAL DISEASE, PANAMA CANAL DEPARTMENT

Month, 1918	Strength, Average	Number of Prophylactic Treatments	Monthly Rate per Thousand	Number of New Venereal Disease Cases	Monthly Average of New Venereal Disease Cases per Thousand	Annual Rate of New Venereal Disease Cases per Thousand
January	10,832	2,302	208.6	79	7.298	87.516
February	10,749	1,847	171.9	99	8.47	101.64
March	10,863	2,072	190.8	87	7.66	84.96
April	10,906	1,384	126.6	74	6.36	76.32
May	10,224	1,811	175.5	69	6.68	80.18
June	10,498	19	1.7	51	4.85	58.20
July	10,991	17	1.6	15	1.36	16.32
August	10,876	3	0.292	7	0.64	7.68
September	10,838	2	0.17	2	0.18	2.16
October	11,811	6	0.508	2	0.16	1.92
November	12,466	20	1.5	4	0.35	4.56
December	12,010	47	3.9	3	0.41	4.92
1919						
January	11,773	44	3.6	12	1.01	12.12
February	10,536	40	3.7	6	0.569	6.82
March	7,488	60	8.01	26	3.47	41.64
April	6,044	68	8.09	25	4.15	49.80
May	4,903	56	11.2	21	4.28	51.36
June	4,620	100	21.34	22	4.82	59.16
July	4,640	571	120.04	36	8.4	10.8
August	4,640	1,209	260.56	84	18.1	21.73
September	4,101	811	197.75	36	8.77	105.24

That it is possible to limit exposures, and hence to limit venereal disease in a community was definitely proved in Porto Rico as shown by the shorter table, from Camp Las Casas. The venereal admission rate for the American Army in Porto Rico in 1898 for the first six months was 467.8 per thousand.

TABLE 2.—CHEMICAL PROPHYLAXIS AND VENEREAL DISEASE AT CAMP LAS CASAS, PORTO RICO

Month, 1918	Average Strength	Number of Prophylactic Treatments	Number of New Cases of Venereal Diseases
June	2,905	10	0
July	8,614	13	2
August	11,656	6	7
September	12,216	5	7
October	12,311	2	1
November	12,389	4	3

The story of venereal disease prophylaxis in these communities is too long for retelling here. Some of the salient features may be learned by reviewing:

Goodman, Herman: Genital Defects and Venereal Diseases Among Porto Rican Draft Troops, THE JOURNAL, March 29, 1919, p. 907; Prostitution and Community Syphilis, *Am. J. Pub. Health* **9**: 515 (July) 1919; Prostitute in Jail, *Med. Rec.* **97**: 483 (March 20) 1920; Law Enforcement Reduces Venereal Disease Incidence, *Soc. Hyg. Bull.*, May, 1920, p. 7; Regulation vs. Abolition of Prostitution, *Med.-Legal J.* **37**: 52, 73, 1920; Regulation vs. Suppression of Prostitution, *Western Med. Times* **40**: 270, 1921. Report of the Governor of Porto Rico to the Secretary of War, 1919. Notes and Comments, Social Hygiene **8**: 259 (April), 399 (July) 1919.

Conditions differ in various parts of the world, yet one could not ask for a more difficult place to demonstrate venereal prophylaxis by reduction of exposures than in a brigade of native troops in the tropics, as was done in Porto Rico, or among Americans in Panama.

HERMAN GOODMAN, M.B., New York.

THE CASE OF WILLETTA HUGGINS

To the Editor:—In THE JOURNAL, June 17, appeared an account of the remarkable sense-perceptions shown by Willetta Huggins before the Chicago Medical Society. This report is followed by Professor Jastrow's comment on the exhibition of the girl's astounding and to him incredible power of smell and touch. It is his comment that prompts this letter.

I have known of some remarkable feats in the way of touch and smell displayed by persons whose absolute blindness was beyond question. For instance, in the Philadelphia School for the Blind where I was a pupil in my boyhood was a girl born without sight whose delicacy of touch was such that she was able to read with ease through four thicknesses of a muslin handkerchief the books of raised letters ordinarily used by sightless persons. In the Perkins School for the Blind in Boston I believe was at one time a young woman (her name I do not recall) who was said to be able by the sense of smell alone to assort correctly the laundered clothes of the children of the institution.

Those are instances of such unusual development of special senses that it makes it not very difficult to accredit to Miss Huggins special powers of sense-perception without, as intimated by Professor Jastrow, the "will to believe." Indeed, so far am I from being willingly credulous as regards all that Willetta does, that I cannot but believe she must see and hear slightly. In fact, I so expressed myself in a letter to Mr. Hooper, superintendent of the Janesville School, last autumn.

In his reply he stated that he and others had subjected her to tests that seemed to prove beyond question her total deafness and blindness. Nevertheless, I am so staggered by her seeming ability to read what is said by the vibrations imparted to a pole resting on the head of the speaker that I still question whether she cannot hear to a limited degree.

There is nothing impossible in Willetta's ability to understand words by resting her hand on the top of the speaker's head or on the chest. I am staggered again by her seeming ability to detect by smell the various colors in skeins of wool or silk, and still more by her recognition in the same way of the colors of natural flowers all of the same kind. Therefore, to set this whole matter at rest, I hope Mr. Hooper will see fit to shut out all possibility of light by sealing the eyelids by means of court plaster and of excluding all sounds by plugging the girl's ears with some substance, as putty or chewing-gum, and finally test the pole experiment by having some nonconductor, as glass, placed between the skull and the end of the stick.

In conclusion, let me say I am still of an open mind and only desire to have this question settled beyond the peradventure of a doubt.

ROBERT H. BABCOCK, M.D., LL.D., Chicago.

Queries and Minor Notes

ANONYMOUS COMMUNICATIONS and queries on postal cards will not be noticed. Every letter must contain the writer's name and address, but these will be omitted, on request.

PENETRATION OF ROENTGEN RAY

To the Editor:—The theory of the roentgen ray as to distance is accepted as light: that it has a penetration in proportion to the square of the distance inversely. For example, 5 inches from the tube, $5 \times 5 = 25$; 7 inches from tube would be $7 \times 7 = 49$, or about one-half of the penetration; or you would say the same of feet in place of inches: 5 feet twice as strong as 7 feet. I do not believe that this is true at these different distances. The three rays given off the roentgen ray—alpha, beta and gamma—all have different velocity and penetration and are very unlike light in many ways. They cannot be refracted or deflected from a straight line, and they have many other properties unlike light. I would be glad to have expert view on this subject.

PAUL PENISTON, M.D., Newnan, Ga.

ANSWER.—The "inverse square of the distance" law has no reference to penetration by the roentgen ray. It simply refers to the intensity at different distances from a given roentgen-ray tube in operation. This intensity varies inversely as the square of the distance in spite of the fact that the beam of the roentgen ray is made up of a number of different qualities of roentgen ray, these variations in quality depending on the variations in wave length.

The beam of light from an ordinary lamp is also made up of various qualities of light, depending on the wave length; i. e., in the beam there is light of various colors from the red to the violet ends of the spectrum. However, disregarding the very small absorption in air, the intensity of light on any given surface falls off inversely as the square of the distance from the source of the light to that surface. Exactly the same thing is true of the roentgen ray. Disregarding the small amount of absorption in air, roentgen-ray intensity (not penetration) will fall off inversely as the square of the distance from the source.

There seems to be a misunderstanding in one part of our correspondent's letter in which he states that alpha, beta and gamma rays are given off by a roentgen-ray tube. Radium gives off these three kinds of rays. Alpha rays are ejected particles of gas; beta rays are electrons; gamma rays are electromagnetic waves.

Only the electromagnetic waves are given off from a roentgen-ray tube; i. e., only rays similar to gamma rays. It is probably misleading, however, to call them gamma rays, because they are very different in wave length and consequently in quality and penetration from the very short wave lengths given off by radium. The correspondent has been misled fundamentally by confusing intensity with penetration. Intensity refers to the amount of roentgen ray, and penetration to the quality.

SPINAL SUBARACHNOID BLOCK

To the Editor:—What is the cause of spinal subarachnoid block in spinal meningitis? I have wondered whether opisthotonos were not responsible, but can find no literature on the subject.

G. T. SPENCER, M.D., South Bend, Texas.

ANSWER.—By "spinal subarachnoid block" a condition is meant in which the flow of cerebrospinal fluid is interrupted by an obstruction in the spinal canal, the usual cause of which is meningitic exudates or a spinal cord tumor. The condition has become well known since the method of suboccipital puncture into the cisterna magna has come into vogue. The patient is made to lie horizontally on one side, and needles are inserted into the cisterna and the lumbar sac at the same time and manometric readings are made. Normally the pressure is the same, while in "block" the cistern pressure is higher. Furthermore, the appearance and the chemical and cytologic condition of the two samples of fluid may vary greatly. Thus, in a case of meningitis with the "block" in the cervical or thoracic region, a small amount of clear or nearly clear fluid under low pressure and with a low cell count might be secured by lumbar puncture, while the cisterna fluid might be purulent and under high pressure. Another form of "block" occurring in meningitis is the "ventricular block" caused by closure by inflammatory exudate of the foramina of Magendie and Luschka by which the ventricles communicate with the subarachnoid space. In this case both the cisterna magna and the spinal subarachnoid space are distal to the obstruction. In order to demonstrate the different pressure and character of the fluid above and below the obstruction and to relieve the serious pressure

symptoms due to the resulting acute hydrocephalus, ventricular puncture is necessary. As early as 1908, Cushing and Sladen (*J. Exper. Med.* **10**:548, 1908) reported successful treatment of ventricular block by puncture of a ventricle and injection of serum. More recently, De Witt Stetten and Dudley Roberts (THE JOURNAL, Jan. 25, 1919, p. 244) devoted a paper to this subject and advocated ventricular drainage by puncture of the corpus callosum. The subject of spinal subarachnoid block is discussed by Paul Wegeforth, J. B. Ayer and C. R. Essick (*Am. J. M. Sc.* **157**:789 [June] 1919), who describe fully the technic of cisterna puncture.

Medical Education, Registration and Hospital Service

COMING EXAMINATIONS

ALABAMA: Montgomery, July 11. Chairman, Dr. Samuel W. Welch, Montgomery.

ARIZONA: Phoenix, July 6-7. Sec., Dr. Ancil Martin, 207 Goodrich Bldg., Phoenix.

COLORADO: Denver, July 5. Sec., Dr. David A. Strickler, 612 Empire Bldg., Denver.

CONNECTICUT: Hartford, July 11-12. Sec., Reg. Bd., Dr. Robert L. Rowley, 79 Elm St., Hartford.

CONNECTICUT: New Haven, July 11. Sec., Eclec. Bd., Dr. James Edwin Blair, 730 State St., Bridgeport. Sec., Homeo. Bd., Dr. Edwin C. M. Hall, 82 Grand Ave., New Haven.

DISTRICT OF COLUMBIA: Washington, July 11. Sec., Dr. Edgar P. Copeland, Stoneleigh Court, Washington.

HAWAII: Honolulu, July 10. Sec., Dr. G. C. Milnor, 401 Beretania St., Honolulu.

ILLINOIS: Chicago, June 26-29. Sept. of Registration, Mr. V. C. Michels.

INDIANA: Indianapolis, July 11-13. Sec., Dr. W. T. Gott, State House, Indianapolis.

MAINE: Augusta, July 5-6. Act. Sec., Dr. Adam P. Leighton, Jr., 192 State St., Portland.

MASSACHUSETTS: Boston, July 11-13. Sec., Dr. Samuel H. Calderwood, 144 State House, Boston.

NEW MEXICO: Santa Fe, July 10-11. Sec., Dr. R. E. McBride, Las Cruces.

NEW YORK: Albany, Buffalo, New York City and Syracuse, June 26-29. Assistant, Professional Examinations, Mr. Herbert J. Hamilton, State Education Bldg., Albany.

NORTH DAKOTA: Grand Forks, July 4-7. Sec., Dr. G. M. Williamson, 860 Belmont Ave., Grand Forks.

OKLAHOMA: Oklahoma City, July 11-12. Sec., Dr. J. M. Byrum, Shawnee.

OREGON: Portland, July 4. Sec., Dr. Urling C. Coe, 1208 Stevens Bldg., Portland.

PENNSYLVANIA: Philadelphia and Pittsburgh, July 11. Sec., Mr. Thomas E. Pinnegan, State Capitol, Harrisburg.

RHODE ISLAND: Providence, July 6-7. Sec., Byron U. Richards, State House, Providence.

SOUTH CAROLINA: Columbia, June 27. Sec., Dr. A. Earle Boozer, 1806 Hampton St., Columbia.

SOUTH DAKOTA: Waubay, July 18. Director, Dr. H. R. Kenaston, Bonesteel.

UTAH: Salt Lake City, July 5. Director, Mr. J. T. Hammond, State Capitol, Salt Lake City.

WASHINGTON: Olympia, July 11. Sec., Mr. William Melville, Olympia.

WEST VIRGINIA: Martinsburg, July 11. State Health Commissioner, Dr. W. T. Henshaw, Charleston.

WISCONSIN: Milwaukee, June 27-29. Sec., Dr. John M. Dodd, 220 E. Second St., Ashland.

Oklahoma January Examination

Dr. J. M. Byrum, secretary, Oklahoma State Board of Medical Examiners, reports the written examination held at Oklahoma City, Jan. 10-11, 1922. The examination covered 11 subjects and included 100 questions. An average of 75 per cent. was required to pass. Four candidates were examined, all of whom passed. Two candidates received duplicate licenses. Eleven candidates were licensed by reciprocity. The following colleges were represented:

College	Year Grad.	Per Cent.
PASSED		
College of Physicians and Surgeons, Chicago	(1901)	75
St. Louis College of Physicians and Surgeons	(1921)	85
Memphis Hospital Medical College	(1901)	80
Fort Worth School of Medicine	(1910)	87
LICENSED BY RECIPROCITY		
Atlanta Medical College	(1914)	Georgia
Chicago College of Medicine and Surgery	(1914)	Missouri
Rush Medical College	(1897)	California
Louisville and Hospital Medical College	(1908)	Kentucky
University of Louisville Medical Department	(1907)	Kentucky
Tulane University	(1911)	Missouri
John A. Creighton Medical College	(1905)	Nebraska
Barnes Medical College	(1904)	Iowa
Eclectic Medical Institute	(1892)	Kansas
Vanderbilt University	(1921)	Tennessee
Medical College of Virginia	(1915)	Virginia

Oregon January Examination

Dr. Urling C. Coe, secretary, Oregon State Board of Medical Examiners, reports the written examination held at Portland, Jan. 3-5, 1922. The examination covered 12 subjects and included 110 questions. An average of 75 per cent. was required to pass. Of the 19 candidates examined, 13, including 1 osteopath, passed, and 6, including 2 osteopaths, failed. The following colleges were represented:

College	Year Grad.	Number Licensed
PASSED		
George Washington University	(1907)	1
Bennett Medical College	(1911)	1
Northwestern University	(1896), (1917)	2
Homeopathic Medical College of Missouri	(1900)	1
St. Louis University School of Medicine	(1921)	2
University and Bellevue Hospital Medical College	(1914)	1
University of Oregon	(1920), (1921)	2
Western University	(1904)	1
University of Bombay	(1919)	1
Osteopath		1
FAILED		
Hahnemann Medical College and Hospital of Chicago	(1921)	1
Southwest School of Medicine and Hospital	(1916)	1
University of Oregon	(1921)	2
Osteopaths		2

West Virginia January Examination

Dr. W. T. Henshaw, secretary, West Virginia Public Health Council, reports the oral, written and practical examination held at Charleston, Jan. 10-11, 1922. The examination covered 9 subjects and included 108 questions. An average of 80 per cent. was required to pass. Of the 12 candidates examined, 5 passed and 7, including one undergraduate, failed. The following colleges were represented:

College	Year Grad.	Per Cent.
PASSED		
Northwestern University	(1920)	84
Tulane University	(1921)	81
University of Maryland	(1920) 91, (1921)	90
Meharry Medical College	(1917)	80
FAILED		
College of Physicians and Surgeons, Boston	(1915)	68
Barnes Medical College	(1907)	*
Meharry Medical College	(1916)	46
University of Lille	(1905)†	41
National University, Athens	(1913)† 66, (1915)†	67
Undergraduate		34

Dr. Henshaw also reports that from October, 1921, to January, 1922, eleven candidates were licensed by reciprocity. The following colleges were represented:

College	Year Grad.	Reciprocity with
LICENSED BY RECIPROCITY		
Georgetown University	(1916)	Dist. Colum.
Georgia College of Eclectic Medicine and Surgery	(1912)	S. Carolina
Tulane University	(1916)	Mississippi
Johns Hopkins University	(1916)	Maryland
St. Louis University School of Medicine	(1919)	Missouri
Washington University	(1919)	Wisconsin
Fordham University	(1918)	Connecticut
Ohio State University College of Medicine	(1915)	Ohio
Jefferson Medical College	(1916)	Penna.
Medical College of Virginia	(1916)	Virginia
University of Virginia	(1896)	Virginia

* No grade given.
† Graduation not verified.

Connecticut March Examination

Dr. Robert L. Rowley, secretary, Connecticut Medical Examining Board, reports the written examination held at Hartford, March 14-15, 1922. The examination covered 7 subjects and included 70 questions. An average of 75 per cent. was required to pass. Of the 21 candidates examined, 17 passed and 4 failed. The following colleges were represented:

College	Year Grad.	Per Cent.
PASSED		
Rush Medical College	(1917)	*
Baltimore Medical College	(1913)	75
College of Physicians and Surgeons, Baltimore	(1904)	75
Johns Hopkins University	(1914)	*
Harvard University	(1904)* (1921)	87.2
Tufts College Medical School	(1914),* (1921)	79.6, 80
Columbia University	(1913) 77.1, (1921)	85
Jefferson Medical College	(1920)	88
Temple University	(1921)	80.4
University of Pennsylvania	(1920)	85
University of Vermont	(1921)	81, 82.5, 84.9
FAILED		
Medical School of Maine	(1898)	*
University of Pennsylvania	(1918)	*
University of Naples	(1913)† 60, (1920)†	59.7

* No grade given.
† Graduation not verified.

Social Medicine

THE DISADVANTAGES AND LIMITATIONS OF CLINIC OR GROUP MEDICINE

GORDON WILSON, M.D.
Professor of Medicine, University of Maryland School of Medicine
BALTIMORE

The terms "group practice" and "clinic medicine" have been applied to quite a number of methods of practice, the main factor in all, however, being that the patient is attended, the word "attend" being used in its broadest sense, by a group of physicians rather than by one.

For the purpose of this paper I have limited the discussion of "Group Practice" to what is generally understood as consultation practice, in which the patient seeks other advice than that of his usual medical adviser or his physician seeks consultation.

It was the custom of Osler, and is the custom of all good internists of today, to seek special advice when they deem it necessary; but this advice is sought in each case from the specialist who, in the given case, can best advise, and not necessarily from the specialist who is allied with the group head; and it is on this fundamental point that group practice differs today from good consultation practice.

In a critical study of any popular movement, it is desirable to know its origin and ascertain, if possible, the underlying causes for its beginning and growth.

The successful start of group medicine might be said to date from the recognition of the excellent work done by the Mayo brothers and their associates at Rochester, Minn., such recognition occurring between the years 1905 and 1910.

FACTORS IN GROWTH OF GROUP PRACTICE

In trying to ascertain the causes leading up to this radical change in procedure, it is well to try to visualize the conditions of medical learning and education, and the advance in medical and allied sciences during the preceding quarter century.

Medical education in this country was essentially clinical, and showed but moderate advance and improvement from its beginnings in the opening of the nineteenth century up to 1906, at which time the number of schools had increased to a total of 162, the maximum number ever reached, the greatest number of matriculates, however, being in 1904, in which year more than 28,000 students were matriculated. The brilliant work of Pasteur and other scientists had by this time become so generally recognized that it was necessary to recast medical education entirely and give the necessary training in what we term today the scientific branches, which meant that no college could exist on the fees paid by students; and as a result of this, as well as the pressure of an enlightened medical public opinion, the number of colleges has decreased since that date to sixty today, which are recognized as giving a satisfactory four year course in medicine. The leading physicians of the country, as a class, at the time of the first broad recognition of the success of the Mayo Clinic, were men who had graduated in the period prior to the marked improvement in medical education, and for that reason many of them had only a theoretical knowledge of scientific advances, and were, in a measure, incapable of using these advances to their best advantage. It was during this quarter of a century that specialism made its great advance, as a result not only of the advances in medicine proper during this period, but also of advances and discoveries in kindred sciences, the roentgen ray and the electric light being examples. While these advances tended, as a whole, to develop specialism, there were a few which, on the other hand, allowed the general practitioner to encroach upon the specialist's field, such an advance being in the development of the electrical ophthalmoscope, which permits the trained internist of today to know the fundus of the eye as he never knew it prior to the use of this instrument.

The formation of new specialties, and growth in all, made it impossible for the internist to keep abreast of this rapid advance in knowledge, though to a far less extent than is generally supposed in the diagnostic side, as contrasted with the operative or therapeutic.

FOCAL INFECTION THEORY

An even greater factor in the growth of group practice has been the wide acceptance of the "focal infection" theory of disease, and the development of surgical technic to the point at which the immediate dangers from an operation are so slight that frequently an operation is used, like quinin, as a therapeutic test, and, like quinin, frequently fails to cure the condition.

The history of the growth of the "focal infection" theory is of interest. From the standpoint of therapy it might be said to date from the report[1] on rheumatic fever, of a committee of the British Medical Association, published in 1889, which called attention to the frequency with which rheumatic fever was preceded or ushered in by a sore throat. An even earlier paper bearing on this theory was that of Riggs[2] in 1875, in which he called attention to the association of pyorrhea and "rheumatism," and showed that, following the curing of the pyorrhea, the rheumatism had disappeared. Riggs insisted that the systemic condition was due to the pyorrhea, and not the reverse, as was generally accepted then. This paper made no impression at the time beyond the giving of a personal name to pyorrhea.

The report of the British Medical Association committee did, however, bear fruit, and slowly from this time onward the tonsils were recognized as the portal of entry for the organism causing rheumatic fever, with its serious complication of carditis, and there resulted the practice of removing the tonsils and thus preventing other attacks.

The wide acceptance of the "focal infection" theory, both by the profession and by the public at large, played a large part in the growth of specialism, since it was believed by the public and by the profession that only the specialist was able to decide whether or not a tissue (or organ) was diseased. The ground for this belief on the part of the profession was the vast literature that had accumulated, so vast that no one mind could keep abreast of it, and few realized that this literature contained relatively little pertaining to diagnosis, and that even that was controversial to a large degree.

Today, the difficulty in determining the focus of infection, or portal of entry, is not in finding a tissue that is pathologic but in deciding whether the lesion is "historical" or healed, or whether it is active. In discussing this point let us take up that small area of the body that accounts for more than 90 per cent. of "foci" that are treated medically or surgically, namely, the mouth and nose, and the structures adjacent. Here, the tonsils and teeth are most frequently looked on as the offending members; and can we tell always, or even frequently, whether a lesion is healed or not? Today, laryngologists differ as to the tonsils, some condemning the submerged tonsils, others the hypertrophied, others again those showing adhesions, or atrophic, while some judge by

1. Cheadle, W. B.: Harveian Lectures on the Various Manifestations of the Rheumatic State as Exemplified in Childhood and Early Life, Lancet 1:872, 1889.

2. Riggs, J. W.: Suppurative Inflammation of the Gums and Absorption of the Gums and Alveolar Process, Western Dental J. 12:529, 1898 (republication).

the degree of enlargement of the tonsillar glands. Within the past year I have asked three prominent laryngologists of my home city as to who was the better judge of the need of a tonsillectomy, the laryngologist or the good family physician, and all three unhesitatingly said the latter.

If a tonsillectomy were a minor operation, this difference of opinion would matter little in most cases; but this is far from being the case, save in young children, and even here the growing list of lung abscesses following tonsillectomy makes one hesitate to say that there is little or no danger in the operation.

With reference to the teeth there is an equal divergence of opinion. A few years ago any tooth was condemned at once if a roentgenogram disclosed bone absorption around the apex; but careful scientific work, such as that recently reported in a dental journal,[3] has taught us that these areas are frequently sterile and remain so, and play no part in metastatic disease. I recall vividly two cases in the past bearing on this point. In one, the patient was an extremely good looking middle aged woman suffering from infectious arthritis of the knee, who had been advised by her physician and her dentist to have extracted a second molar and an upper central incisor. She did not mind losing the molar, but objected strongly to parting with the incisor, and consultation was sought. As a compromise, only the molar was extracted; the patient saved her front tooth, and there was recovery from the arthritis and no return of it in the six years that have elapsed. The other case was that of a young girl, a psychasthenic who had had all of her teeth extracted on account of a mild arthritis; following this extraction, and undoubtedly caused by it, there had developed the mental attitude that made life almost unbearable.

These two cases are cited to show that even extractions of teeth are not always minor events.

The difficulty of determining activity of disease elsewhere than in the area cited is, on the whole, more difficult than when tissues can be seen. Brown,[4] in discussing the after-effects of operations on the upper abdomen, has shown that diagnostic operations, unlike quinin, are not harmless.

THE INDIVIDUAL AND THE GROUP

All that I have so far said with reference to "focal infection" would apparently apply with equal force to the consultant of the Osler type as to the head of a diagnosis clinic, save in two important factors. The first factor of importance I have already referred to in contrasting the choice of specialists afforded in one case in getting advice, as compared with its lack in the other. An even more important factor is the feeling of individual responsibility that cannot be present to the same degree when the "buck can be passed" so readily as in the diagnostic clinic.

Professions and occupations differ widely in their technic, but have many points of contact where organization is concerned, and in that broad twilight zone having to do with human nature.

Business has learned, as indicated by such terms as "soulless corporation," that superorganization has its penalties, and the trend today in political development is to individualize responsibility, as leading to efficiency.

A claim made frequently for the diagnostic clinic is that, through the thoroughness of numerous examinations, diagnoses are arrived at that would be missed by the trained diagnostician. This is true in a very small percentage of cases, this percentage depending entirely on the ability and routine of the consultant, as compared with that of the diagnostic head of the group. If all diagnostic tests caused no discomfort, pain or danger it would undoubtedly increase the percentage of early diagnoses to use all tests on every patient; but I doubt whether any clinic or group has adopted, for example, routine cystoscopic examination which would from time to time disclose a bladder tumor when no signs or symptoms had arisen to direct attention to its possibility.

A danger today of clinic or group medicine is the doing of unnecessary things at the patient's expense in time, pain, danger or cash expenditure. Sir James Mackenzie[5] has called attention to this, saying:

> Suppose a physician directs these researches: the very fact that he has to call in the help of others implies that he is not able to detect the phenomena produced by disease; and if he is not capable of doing this, how can he be qualified to assess their value?

The discussion so far has dealt more with what interests the physician—diagnosis—as contrasted with what interests the patient—therapy; and there is evidence that group medicine today is leaning to that fallacy of all medical cults, the treating of disease rather than the patient. Any one who has had experience with good hospitals and sanatoriums, both large ones and small ones, knows that the therapy is better in the small one through individualism, necessarily lacking to the same degree in a large hospital, which must have organization to exist.

CONCLUSION

I cannot help recalling a remark I laughed at some years ago, when a very shrewd countryman surprised me by saying that he preferred an elder physician to a younger and better trained man, and gave as his reason that "he knew his constitution." If he had only said "psychologic reaction" I would not have laughed.

4 East Preston Street.

3. Rickert, U. G.: Report of Research Committee, Financed by the Michigan State Dental Society, J. Nat. Dental A. 2: 300, 1922.
4. Brown, T. R.: Late Results of Supposedly Successful Abdominal Operations on the Digestive Tract, J. A. M. A. 73: 1501-1504 (Nov. 15) 1919.

5. Mackenzie, James: The Future of Medicine.

Book Notices

MANUAL OF OBSTETRICS. By John Osborn Polak, M.Sc., M.D., F.A.C.S., Professor of Obstetrics and Gynecology in the Long Island College Hospital. Second edition, containing a special section on Endocrinology. Cloth. Price, $6. Pp. 488, with 122 illustrations. New York: Physicians and Surgeons Book Company, 1922.

This book suffers mostly from inadequate editing and proofreading. For instance, in the competent execution of these offices the proofreader would have corrected the disparity in spelling between Haas' rule on page 55 and Haase's rule on page 105, while the editor would have eliminated at least one appearance of this unimportant item. The proofreader would have put only one t in vitelline, and the editor would have reconciled the statement on page 180 that, among primiparas, 34 per cent. are lacerated in labor, with the figures six pages later of from 10 to 40 per cent. The editor, again, would have made the measurements of the fetal head as given in the text correspond with those printed on the accompanying illustration, and he would have omitted one of the two pictures of the fetal circulation, though both are good. We do not approve of the use of 2 per cent. solutions of silver nitrate in the eyes of the new-born when a 1 per cent. solution is adequate. However, if the stronger solution is employed, it should be neutralized by physiologic sodium chlorid solution, as advised on page 221; but the editor should have seen to it that the same routine was prescribed on page 235, lest the observance of only the second admonition might lead to the injury of some eye. Differences of opinion are wholesome, of course; but in a work written professedly to hand down accepted doctrine to students and practitioners it would be fairer to admit that the causes of labor are unknown than to attribute etiologic importance to merely

associated phenomena like the menstrual epoch, increased fetal movements, and a loose attachment of the egg. It would be more conservative and more in harmony with authority also to give the length of the mature fetus as from 48 to 53 cm. rather than from 45 to 50 cm. We regret to note also that in the treatment of mastitis the author still advises the use of the archaic binder. In his description of episiotomy, both the student and the practitioner would be grateful to have the reasons and advantages of this excellent operation as fully set forth as the technic of its performance. It seems, too, that the prognosis in hemophilia of 80 per cent. mortality is unduly high when probably 90 per cent. recover under treatment by transfusion, which is not mentioned. Probably the most serious objection to the work is the habitual use of illustrations in which neither the hands of the operator are gloved nor the vulva is shaved. The author gives an elaborate and satisfactory preparation for aseptic interference, while the accompanying pictures would indicate that the routine is not carried out. As a whole, the book represents the standards of work that are recognized in all the better clinics. The operative technic is good, the chapter on ectopic gestation excellent, and the introduction of endocrinology a novel and valuable feature. Probably in the next edition the author can secure a better balance of his material, as well as more coherence and unity.

THE CLINICAL STUDY OF THE EARLY SYMPTOMS AND TREATMENT OF CIRCULATORY DISEASE IN GENERAL PRACTICE. By R. M. Wilson, M.B., Ch.B. With a foreword by Sir James Mackenzie, M.D., F.R.S., F.R.C.P. Cloth. Price, $4.75. Pp. 245, with 111 illustrations. New York: Oxford University Press, 1921.

Sir James Mackenzie has many times, and with good reason, urged the importance of a restudy of symptoms. Largely through his influence Wilson has begun an investigation whose results are embodied in this volume, which is in the nature of a preliminary report. The effort has been not so much to seek for new symptoms of circulatory disease as to reconsider the nature and significance of symptoms with which we have long been familiar, such as exhaustion, pulse rate, breathlessness and pain. The book is well worth reading. One may, perhaps, question the justness of some of the conclusions of the author, but one is nevertheless impressed by the many facts that are presented in a new light, and is stimulated to a keener and more intelligent interest in the common, everyday symptoms of disease. It is to be hoped that reports of the progress of these investigations may from time to time appear.

NUTRITION AND GROWTH IN CHILDREN. By William R. P. Emerson, A.B., M.D., Professor of Pediatrics, Tufts College Medical School. Cloth. Price, $2.50. Pp. 342, with 38 illustrations. New York: D. Appleton & Co., 1922.

Dr. Emerson's methods for improving nutrition and growth of children have received considerable attention in medical literature during recent years. In the present book, prepared for the public as well as for the medical profession, he describes his method in detail, including directions for general care, as well as complete outlines on diet and food habits. The book is extensively illustrated, and contains numerous tables, diagrams and charts which constitute a part of the system. It will be found especially valuable by all interested in public school and other educational work in nutrition.

A HALF CENTURY OF PUBLIC HEALTH. Jubilee Historical Volume of the American Public Health Association in Commemoration of the Fiftieth Anniversary Celebration of Its Foundation. Edited by Mazyck P. Ravenel, M.D. Paper. Price, $3.75. Pp. 461. New York: American Public Health Association, 1921.

This book contains nineteen articles of an historical nature by members of the American Public Health Association. It is dedicated to Dr. Stephen Smith, founder and first president, who contributes an interesting article on the history of public health during the period 1871 to 1921. The articles by Ravenel and Bryce also contain much of interesting personal history in connection with the public health movement in this country and in Canada. The history of bacteriology, mortality, quarantine, governmental control of disease, water purification, sewage removal, stream of pollution and its control, food conservation and control, child welfare work, housing, including ventilation, industrial hygiene, entomology and public health nursing, with special reference to the last fifty years, is presented by recognized experts in the respective fields. The American Public Health Association is congratulated on having secured such a valuable and comprehensive historical review of public health activities to mark its fiftieth anniversary.

THE SECRET PLACES OF THE HEART. By H. G. Wells. Cloth. Price, $1.75. Pp. 287. New York: The Macmillan Company, 1922.

The most recent novel of the prolific H. G. Wells concerns principally the illness of a British fuel commissioner, and the advice tendered him by his physician and psychanalyst. The chief value of the book, however, lies not in its medical considerations, but in the picture drawn by the author of a motor tour through rural England, during which the principal characters discuss the application of psychanalysis to mental illness fervidly and profusely. American psychanalysts who follow closely the technic of Freud and his disciples will insist that the methods followed by Mr. Wells' physician were so far from correct that his case report has no scientific value. On the other hand, the experience was enlightening and instructive, especially as subsequent events in the novel confirm the diagnosis. As a novel, this book is not up to the standard of the author's best productions; but as a story with a purpose, it will be found to show all the craftsmanship of which so great a writer as Mr. Wells is capable.

DISEASES OF THE EYE. A Handbook of Ophthalmic Practice for Students and Practitioners. By George E. de Schweinitz, M.D., LL.D., Professor of Ophthalmology in the University of Pennsylvania. Ninth edition. Cloth. Price, $10, net. Pp. 832, with 422 illustrations. Philadelphia: W. B. Saunders Company, 1921.

In this new edition, Dr. de Schweinitz has brought his book up to date, revising all of the various sections to accord with important ophthalmologic observations appearing in periodical literature. In his preface he records more than a score of new topics to which reference is now made for the first time, including, for example, new tests for color blindness, new operations, and several newly described forms of ophthalmic infection. An elaborate index of almost sixty pages makes reference to any special subject a very easy matter. Dr. de Schweinitz' book is the most complete single volume reference work on ophthalmology available in English, and is generally considered to be authoritative.

AN INDEX OF TREATMENT. By various writers. Edited by Robert Hutchison, M.D., F.R.C.P., Physician to the London Hospital, and James Sherren, C.B.E., F.R.C.S., Surgeon to the London Hospital. Revised to Conform with American Usage by Warren Coleman, M.D., Assistant Professor of Medicine, University and Bellevue Hospital Medical College. Eighth edition. Cloth. Price, $12. Pp. 1029, with 88 illustrations. New York: William Wood & Co., 1921.

This encyclopedic work is prepared in England, and the American edition is edited so as to make the various prescriptions conform to the standards of the United States Pharmacopeia. It therefore represents an outline of therapeutics as conducted in Great Britain, which does not accord in every instance with American methods of practice. Virtually every disease known is referred to, and some form of treatment is suggested for each. A supplement provides references to the preparations described which are utilized only in the British methods of practice.

A TEXT-BOOK OF PHYSIOLOGY FOR MEDICAL STUDENTS AND PHYSICIANS. By William H. Howell, Ph.D., M.D., Sc.D., Professor of Physiology in the Johns Hopkins University. Eighth edition. Cloth. Price, $6.50. Pp. 1053, with 308 illustrations. Philadelphia: W. B. Saunders Company, 1922.

In the three years which have elapsed since the publication of the last edition of Dr. Howell's well-known textbook on physiology, there have been no epoch-making advances. However, the points of view on many physiologic subjects have changed, and in particular the application of the knowledge of physiology to clinical medicine has been greatly broadened. Dr. Howell has revised his book to accord with these changes, and has brought it up to date.

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Medicolegal

Powers of Public Health Boards and Officers

(Rock v. Carney et al. (Mich.), 185 N. W. R. 798)

The Supreme Court of Michigan holds that there is power to protect the public health; it is vested by law in public health boards to be exercised through reasonable rules and regulations duly promulgated. Whether such rules and regulations are lawful and reasonable, considering the true end in view and personal rights guaranteed citizens by the constitution, constitutes judicial questions beyond the power of the legislature to foreclose. Arbitrary power, beyond the reach of redress open to an injured citizen, is not vested in boards of health or anywhere else under our system of government.

While courts may well be loath to review health regulations, promulgated by an executive board under legislative delegated authority, yet in a proper case the duty exists, and no board by executive action can close the court and succeed in having its officers remain immune from judicial inquiry when a claimed unlawful exercise of authority has been visited on a citizen and redress is asked. Courts may be controlled by the determination of an executive board skilled as to what constitutes a dangerous communicable disease, and may not attempt to review such classification; but the method adopted or exercised to prevent the spread thereof must bear some true relation to the real danger, and be reasonable, having in mind the end to be attained, and must not transgress the security of the person beyond public necessity.

The board of health has no legislative power; it may under delegated power enact rules and regulations for the protection and preservation of the public health, but must steer clear of combining legislative with executive power; in other words, such a board cannot give itself power and then execute the power.

The law has not yet conferred on boards of health the old time custom of the Samnites of examining the conduct of the young people or of holding general inquisition for the discovery of venereal disease. Act No. 272, Public Acts of 1919, which expressly relates to venereal diseases, was enacted subsequently to the acts complained of in this case, in which the plaintiff sought to recover damages for the alleged unlawful acts in 1918 of the health officer of a city in which a number of soldiers were stationed, he also having been appointed an inspector by the state board of health. When the plaintiff, then 18 years of age, was brought to him by a deputy sheriff, he made an examination, stated that she had gonorrhea, and that she would have to go to a hospital where girls and women were detained and treated for venereal diseases. He, the plaintiff alleged, would not consent to her remaining at home and placarding the house. The court recognizes the need of full power to stay the spread of epidemic diseases, and finds such power in the statutes; but it cannot find there that, by the mere determination that a disease is dangerous and communicable, there follows power at the will of the health officer to refuse isolation in the home by quarantine and placard notice thereof and to commit the diseased person to a hospital. The question arose whether the exercise of the power by the defendant officer in refusing this girl right of quarantine in her own home was an unreasonable act and not warranted by menace to the public health, and whether her confinement in the detention hospital was an unlawful restraint of her person. This presented an issue of fact for the jury, and the trial judge was in error in directing a verdict for the defendant.

The restraint over the person of the plaintiff being made to appear, the burden was on the defendant to justify the same under the authority of some law. It would be an intolerable interference by way of officious meddling for health officers to assert and then assume the power of making physical examination of girls at will for venereal disease. The law of 1919 points out methods for bringing venereal cases to the attention of health officers, but does not sanction what the plaintiff claimed was done in this case; and surely the power of the defendant was not more without law on the subject than it is now with law. If the health officer had power at all to examine the plaintiff, he had no right to exercise it without reasonable cause; such cause to precede examination and in no way to depend on the result of examination. In any event, the defendant had no right to suspect and examine the plaintiff so long as she had no accuser. Wherefore the judgment which was rendered in favor of the defendant is reversed, the costs to abide the final result.

Reputation Not Deemed at Stake—Evidence and Questions in Sponge Case

(Cochran et ux. v. Gritman (Idaho), 203 Pac. R. 289)

The Supreme Court of Idaho, in affirming a judgment for $6,000 damages for injuries from the alleged negligent leaving of a gauze sponge in the abdominal cavity when an appendectomy was performed, says it was not only strenuously insisted that a new trial should be granted for certain alleged errors, but the consideration was urged that above and beyond the pecuniary amount awarded by the jury the professional reputation and good name of the defendant as a physician and surgeon, which it had taken him a lifetime to build up, was at stake. The court, however, does not entertain the view that this result usually follows a verdict of this kind, or that it should do so. In view of the great number of operations performed by surgeons, and the highly technical character of the work, it is greatly to the credit of the profession that comparatively few mistakes are made. The degree of perfection and avoidance of error that a finite being may reach is limited, and there is always a possibility of failure to exercise such care and diligence as is necessary to avoid disastrous results in highly technical work of this character. The law requires only that degree of care which is ordinarily and commonly recognized as reasonable under the particular facts and circumstances of a given case. Society is greatly indebted to modern surgery, and to the skilled and eminent men who devote their lives to alleviating pain and saving life. However, when unsatisfactory results follow an operation of this character, and it is claimed that they were the direct result of failure to exercise such reasonable care as is ordinarily used by surgeons under similar conditions, and there is competent proof offered in support of such claim, the question of whether such care was used as the law requires becomes a question of fact, to be determined by the jury under proper instructions.

The defendant contended that since this wound was septic, and yet healed, when all of the testimony of the experts was to the effect that it could not heal if a foreign body had been left in contact with it, it must conclusively be presumed that no such body was allowed to remain there. A case was cited in which it was held that, when the physical conditions are such as to preclude all reasonable probability that the testimony of a witness is true, it being contrary to well-known physical laws, the jury should be instructed to disregard such testimony. But this court thinks that principle had no application to the facts and circumstances of the case at bar, for the reason that the science of medicine and surgery has not reached such a state of perfection that it can be claimed that, since a given cause will produce a certain result, if such result does not follow it must be presumed that the cause does not exist. Moreover, there was substantial evidence in this case that the wound never did heal.

A prospective juror was asked whether he was a stockholder in any insurance company that insured physicians and surgeons. The trial judge sustained an objection, and instructed counsel for the plaintiff that he was not to mention that at all, and that if there was any insurance company in this case the jury was to know nothing about it; that it was error to suggest such a thing. But the supreme court intimates that this ruling was more favorable to the defendant than the law required, for it would not necessarily be reversible error to inquire of a prospective juror, in a case of this kind, whether he was a stockholder in an insurance company which insures physicians and surgeons.

It was not misconduct for counsel to read from medical authorities the questions he had asked the expert witnesses, when the matter read in each instance was the same matter, with the slight variation necessary to put it in the form of a question, which he asked of the expert witnesses; and when such expert witnesses had stated that the book was a standard authority; so that all of the objectionable matter read was merely a statement in argument of questions propounded to the expert witnesses. It was urged that a hypothetical question asked a surgeon called for his expert opinion with reference to the ultimate question for the jury to decide; but it may be put to the witness hypothetically whether, if certain facts testified to or shown to be within his own personal knowledge are true, he can form an opinion, and what that opinion is. That still leaves the ultimate fact for the jury's decision, giving due weight to the opinion.

Revocation of License for "Practice" of Criminal Abortion on Single Occasion

(Blumberg v. State Board of Medical Examiners (N. J.), 115 Atl. R. 439)

The Supreme Court of New Jersey says that in November, 1920, a complaint was made to the state board of medical examiners that in October, 1916, Blumberg, a licensed physician, "practiced a criminal abortion," the complaint praying that his license be revoked. A hearing, on due notice, such as the statute required, was accorded the accused, and in February, 1921, the board adjudged him "guilty of the practice of criminal abortion" in the case in question, and revoked his license. Thereupon, he sued on a writ of certiorari to have the proceedings and order of revocation reviewed by the court. In affirming the proceedings and order, the court is of the opinion that the action of the state board was right.

The statute provides, among other things, that the board may revoke a license for the "practice of criminal abortion." It was apparently not disputed that the evidence before the board showed that the accused physician performed a criminal abortion as alleged; but the sole contention was that the mere fact of having performed, on a single occasion, an act of criminal abortion did not justify the taking away of his license. He relied on the line of cases holding that to "practice" a calling does not mean to exercise it on an isolated occasion, but to exercise it frequently, customarily, or habitually. But those cases were not in point. The court was not here concerned with the practice of a calling, but rather with the "practice of criminal abortion," for which a physician's license might be revoked, and that did not mean, necessarily, continued or habitual practice of criminal abortion. The object of such a restrictive statute is the protection of the public, and as a member of the public is endangered by one act of criminal abortion, so a single act may be practicing.

Among other definitions of "practice" to be found in Webster's International Dictionary is: "To perform, to do." The court thinks that the term "practice," as used in the statute, means to perform or to do the thing specified in the statute, namely, criminal abortion. It followed that the proof before the board that the accused performed, on a single occasion, an act of criminal abortion, justified the revocation of his license. That such was the intention of the legislature is quite evident. The statute further provides that the license may be revoked for "conviction of crime involving moral turpitude." It must be and was conceded that, if the accused had been indicted and convicted for the single offense considered by the board, his license might have been revoked on such conviction, a plain indication that the legislature intended to authorize the board to revoke the license of one who is shown, by the evidence presented to them, to have performed a "single act of criminal abortion."

Incidentally, it seemed to be suggested that the license could not be revoked because, at the time the proceeding was instituted, the "prosecution, trial, or punishment" for the offense involved was barred by the statute of limitations respecting criminal proceedings. But that was not so. The statute authorizing revocation of the license was not intended as a punishment of the physician for the crime involved, but as a protection of the public, and the statute of limitations was no defense to this proceeding.

Society Proceedings

COMING MEETINGS

Colorado Congress of Ophthalmology and Oto-Laryngology, Denver, July 28-29. Drs. M. D. Brown and J. M. Shields, Metropolitan Bldg., Denver, Secretary.

Florida Medical Association, Havana, Cuba, June 30. Dr. Graham E. Henson, Jacksonville, Secretary.

Idaho State Medical Association, Wallace, July 10-11. Dr. E. E. Laubaugh, Overland Bldg., Boise, Secretary.

Maine Medical Association, Portland, June 27-28. Dr. B. L. Bryant, 265 Hammond St., Bangor, Secretary.

Montana, Medical Association of, Great Falls, July 12-13. Dr. E. G. Balsam, 222 Hart-Albin Bldg., Billings, Secretary.

ASSOCIATION OF AMERICAN PHYSICIANS

Thirty-Seventh Annual Meeting, held in Washington, D. C., May 2-4, 1922

(Continued from page 1919)

The Simultaneous Variation in Acidity of Gastric Contents in Different Parts of the Stomach

DR. FRANKLIN W. WHITE, Boston: I made about 500 analyses of gastric contents in fifty cases after an Ewald test breakfast, by rapid (one-half minute) and slow (from fifteen to twenty minutes) fractional methods. The position of the tube tip was located by the fluoroscope. The content of the stomach at the end of an hour is not usually a uniform mixture. The acidity of different fractures taken in rapid succession varies from twenty to thirty points or more in about 40 per cent. of observations. The acidity of single fractions taken at that time does not usually represent the acidity of the contents, as a whole. This simultaneous variation is due not to the variable position of the tube tip in the stomach (fluoroscopic observation) or, as a rule, at that time to variable duodenal regurgitation (tests for trypsin), but to very incomplete mixing of acid secretion with the contents of the stomach. Efforts to overcome this variation by artificial mixing of contents in the stomach and water test meals were partially successful.

DISCUSSION ON PAPERS OF DRS. FITZ AND WHITE

DR. JULIUS FRIEDENWALD, Baltimore: In quite a number of observations made with Dr. Gantt we have observed that this variation may be overcome by repeatedly extracting a large quantity of stomach contents by means of a syringe and returning it into the stomach, thereby producing a homogeneous mixture; the gastric contents will have a uniform acidity. I should like to make a plea for the recognition of the stomach tube as an American invention. It is generally believed that two English surgeons, Jukes and Bush, are the inventors of the stomach tube, a belief based on a paper published by Jukes in the London *Repository* of 1822. That the credit of this discovery is due to Dr. Physick, professor of surgery of the University of Pennsylvania, there can be no doubt. Physick published his original paper in October, 1812 (Account of a New Mode of Extracting Poisonous Substances from the Stomach, *Electic Repertory* 2:111) under the title which is ten years prior to the appearance of Jukes' article.

DR. HENRY A. CHRISTIAN, Boston: Failure to consider carefully the information obtained in these two ways leads to an unnecessary number of gastro-intestinal roentgen-ray studies. If routine roentgen-ray study of patients with gastric symptoms was to be of the greatest possible utility, it would reveal early unsuspected gastric cancers, but this it has failed to do in a single case in my clinic. The roentgen ray often has been useful in helping to differentiate pernicious anemia from cancer of the stomach, but even here the roentgen-ray result usually has been anticipated from the patient's history. Of course, the roentgen ray is very accurate and of great value in determining the presence of ulcer. However, I feel that it should be emphasized to the general practitioner that, by taking a careful history, making a thorough general examination and using the stomach tube intelligently, he can obtain most of the needed data for a diagnosis without

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recourse to the roentgen ray, and that it is better to have no roentgen-ray examination than a poor one.

DR. JOSEPH SAILER, Philadelphia: Some years ago when attempting to determine the value of Mathieu's method for estimating the total gastric contents, I withdrew as much of the stomach contents as possible into a beaker, and then plunged a 10 c.c. pipet into the beaker, withdrawing 10 c.c. at a time from different parts and estimating the total acidity and the free acid. I found that the contents from different parts of the beaker showed considerable variation. This variation was greater if there was mucous and if the chyme was thick, and least if it was thin and clear. It was not entirely eliminated in thick chymes by vigorous stirring. This convinced me at that time that the method of Mathieu was entirely useless for the purpose of estimating gastric contents. One could not even estimate the amount of chyme in a beaker, the contents of which could be tested easily and the results checked. Other methods of estimating the gastric contents were equally futile, and when the method of fractional examination of the gastric contents was introduced, I realized that it could have no real scientific value except in cases of achylia gastrica, where it is still useful. It is just as important to show the fallacies in laboratory tests as it is to invent the tests. Dr. White has demonstrated the comparative uselessness of one of these time-consuming methods.

DR. EMANUEL LIBMAN, New York: As often occurs when one group of men is in favor of one method for diagnosis and a second group in favor of another, both methods can be found of great value if one understands the restrictions attached to each of them. I have encountered a number of cases in which I could not, without the help of the roentgenologist, definitely diagnose the presence of a penetrating ulcer, of an ulcer of the lesser curvature, or of a carcinoma of the stomach. The reason the roentgenologic examinations are often not of as great value as they might be lies in the fact that the work may be done by men not having the proper training. If one obtains the cooperation of a roentgenologist who has studied the physiology of the digestive tract, and who has followed cases to the operating room and to the postmortem table, one can often be very much helped.

DR. FRANKLIN W. WHITE, Boston: The only suggestion I make for overcoming the simultaneous variation in acidity of different portions of gastric contents in routine fractional gastric analysis is to take out larger fractions than 10 c.c., and to mix the gastric contents in the stomach before aspiration. Neither of these suggestions is entirely free from objections. Another important clinical point: Shall we give up fractional gastric analysis because of the large accidental variation in the acidity of the fractions, amounting at times to 50 or 100 per cent. of the actual figures obtained? I am inclined to say no, but we must surely remember that only gross changes in acidity are important; whether we have much free acid or little free acid or no free acid, mathematical details of the gastric acidity have little clinical value.

Recognition and Treatment of Mild Hyperthyroidism

DR. JOSEPH L. MILLER, Chicago: Exophthalmos is no longer essential for the diagnosis. Well recognized cases without visible or palpable enlargement of the thyroid are not infrequently observed. Tachycardia, tremor and increased nervousness are now accepted as the most constant clinical manifestations. To these may be added increased basal metabolism. It is still maintained, however, that these symptoms or signs must be present continually, and not transitory in character. The question arises, Are we, by adhering to this criterion, recognizing all cases of hyperthyroidism? In a disease dependent on extensive or abnormal glandular secretion it is highly probable that all gradations of intoxications occur from the very mild to the more severe type. In sixty-one cases of what we believe was mild hyperthyroidism, the symptoms were transitory, especially the tachycardia, tremor and extreme nervousness. At the time of examination these symptoms might not be observed, and hence the importance of a careful history. The basal metabolism was determined in only twenty-six of these cases. In two it was normal, in one + 7, in the remainder above + 10, and in 66 per cent. above + 20. All of these patients were treated by roentgen ray, with 74 per cent. so greatly improved as to consider themselves cured.

DISCUSSION ON PAPERS OF DRS. WILSON AND MILLER

DR. J. H. MEANS, Boston: I agree with Dr. Miller regarding the limitations of the metabolism determination in diagnosis. One factor that is often not given its due importance is the effect of emotional disturbance. Sometimes an elevation in metabolic rate is found at a first observation which is interpreted as due to hyperthyroidism, when actually it is not. Dr. Lennox at the Massachusetts General Hospital has found that there is a considerable rise in the rate when a patient is told that an operation is to be done. These transient elevations, which may be confused with true hyperthyroidism, are actually, I believe, suprarenal effects. Repeated tests should be made to exclude this possibility in doubtful cases.

The Tremor Type of the Hepatocerebral Denegerations

DR. J. RAMSAY HUNT, New York: I wish to offer a clinical and pathologic contribution to a group of nervous disorders which includes the pseudosclerosis of Westphal-Strümpell; the progressive lenticular degeneration of Kinnier-Wilson, and the dystonia lenticularis of Oppenheim-Thomalla. This group of diseases is characterized pathologically by a progressive cerebral degeneration of peculiar histologic type, and is associated with nodular cirrhosis of the liver. The corpus striatum would appear to be the seat of election, although other portions of the brain, including the brain stem, cerebellum and the cerebral cortex are frequently affected. The histologic changes are characterized by degeneration of the neural structures and peculiar vesicular swelling of the glia cells (Alzheimer's glia cells). The clinical picture is a varied one, depending on the localization of the lesions. The chief clinical types are choreo-athetosis; dystonia musculorum deformans, and Wilson's disease (muscular rigidity and tremor), all of which are referable to the corpus striatum. A more diffuse form, the pseudosclerosis, has also been described with a more general symptomatology. The latter disorder bears a certain resemblance to multiple sclerosis, and is characterized by paralysis, ataxia, sensory symptoms, tremor and mental disturbances. In addition there is a tremor form of this disease, which is characterized by the progressive development of generalized atactiform tremors without other evidence of organic disease of the central nervous system, and also associated with nodular cirrhosis of the liver. The tremor disturbance is both cerebellar and lenticular in origin. One component is the intention tremor type; the other component is slow, rhythmical, and occurring during rest. This combined form of organic tremor I term striocerebellar tremor. Two cases are reported, one with necropsy and histologic examination.

DISCUSSION

DR. LLEWELLYS F. BARKER, Baltimore: What percentage of cases show the influence of heredity?

DR. J. RAMSAY HUNT, New York: A very large percentage of this group of cases is of the heredofamilial type. According to Hall, who has analyzed very thoroughly the literature on this subject, it is as high as 50 per cent.

A Clinical Study of Migraine

DR. CHARLES S. BOND, Richmond, Ind.: This phenomenon is unrelated to eyestrain or toxemia. Previous to the attack, the patient craves and takes more carbohydrates than the stomach can handle, and after some days this material passes from the stomach as fermented product, or there is almost complete gastric retention, as an effort is made to keep acid ferments and carbon dioxid out of the circulation. Preceding the attack, the patient is mentally overstimulated and suffers almost complete digestive stasis. The urine, skin and secretions smell musty. The urine is hyperacid and there is tendency to acidosis. The desire for excess of carbohydrates recalls that of diabetics. While migraine is not hereditary per se, there is no doubt that the mother transmits the vulnerable tissue and the bad table habits, which become fixed, so that it is difficult to correct the bad dietary. These

patients must live free of stress and excitement, and on a low carbohydrate diet. A free use of hydragogue cathartics is advised.

DISCUSSION

DR. L. F. BARKER, Baltimore: In these cases, attention should be paid to the general health and environment. Dr. Starr's powder of sulphates, sodium phosphate and salicylate is very helpful. We can reduce the number of attacks and increase the ability of the patient to stand the attacks, but it is very difficult to get patients free from the attacks. It is distinctly a heredofamilial disease. The migraine disposition must lie in the germ plasm. It is time again to take up the study of constitution or predisposition, and not pay all attention to exogenous causes. We can, by starting in early life, do much to ward off outbreaks of the attack and modify the disposition.

Use of a High Fat Diet in the Treatment of Diabetes Mellitus

DR. L. H. NEWBURGH, Ann Arbor, Mich.: A diet of 900 calories, derived chiefly from fat, produces the same fall in basal metabolism as does starvation. It has advantages over starvation in that it is more successful in desugarization and is a far less dangerous method. A low protein, low carbohydrate, high fat maintenance diet, fed a large group of diabetic patients since March 1, 1918, maintained an aglycosuric state, was not attended by acidosis, maintained nitrogen balance, did not cause a hyperlipoidemia and was attended by its disappearance in those patients in whom it was present at entrance; supplied sufficient energy to avoid the evils of undernutrition; permitted an amount of activity compatible with earning a livelihood, and, within the limits of our observation, was not attended by downward progress in uncomplicated cases.

DISCUSSION

DR. E. P. JOSLIN, Boston: One case which shows the advantage of treatment with the Newburgh diet was that of a boy whose diabetes began five years ago at the age of 10 and who has since been under my care. During this period he has faithfully followed diet, but gained only 13 pounds and increased 2 or 3 inches in height. Recently, during seven weeks' stay at the hospital he failed to become sugar free, but when discharged on a diet based on the principles of the Newburgh-Marsh regimen with a few minor modifications, such as frequent meals, he not only became sugar free, but returned to the hospital at the end of two weeks with a normal blood sugar. Before resorting to a very low carbohydrate low protein and high fat diet as a routine method of treatment, one must be sure that the results with such a diet are as satisfactory as those with the older methods which have been adopted for the milder type of diabetic. Until the Ann Arbor statistics show that a considerable number of diabetics treated with low carbohydrate, low protein and high fat run a more favorable course than those treated with a higher quantity of carbohydrate, a gram of protein per kilogram of body weight, and a moderate number of calories, it would seem hardly justifiable to change the present plan of treatment.

DR. R. T. WOODYATT, Chicago: A year ago I described a method of dealing with diabetic diets. Since then we have handled 425 cases in accordance with the principles described. Of these, 125 were managed in the hospital. Of these patients, only thirteen have died. The preponderance of the cases we handle are severe, and the patients range from early childhood to old age. Complete fasting or near fasting has not been used in a single case. All have been placed on diet from the beginning. In the most severe cases the patients have been given fat up to 2 gm. per kilogram of body weight, even when there were severe acidosis with symptoms of acid poisoning and depleted alkali reserves. I have seen no case in which I thought this quantity of fat did harm or delayed desugarization. In one uncomplicated severe case the patient went into coma while on a diet intended to desugarize. The fat in that case was above 2 gm. per kilogram. This is the only accident we have had with fat replacement diets, and we have never since exceeded the 2 gm. per kilogram of body weight rule during initial treatment of cases with acidosis.

DR. F. M. ALLEN, Morristown, N. J.: I do not see how a patient starved for nine days can be made sugar free on a high fat diet. Were any of these patients children?

DR. L. H. NEWBURGH, Ann Arbor, Mich.: It is not intended to advocate exactly this type of diet for all diabetics. Our intention was to do an experiment with certain rigid diets which we have used invariably with every patient from the beginning of the experiment. For patients with mild diabetes, larger amounts of protein and carbohydrate would not make any difference. However, if one is to make an experiment, one should adhere to the plan from the beginning to the end. For that reason we have used these four diets and have used them thoroughout the experiment without variation in principle. Dr. Allen says that a patient who has been starved for nine days cannot be made sugar free on a high fat diet. We have a thorough record of this case. There seems to be no reasonable question about the fact that she was starved in this way, and I think there should be no question as to the results of 900 calories derived chiefly from fat that she received under our care. She is one example of a group of patients whom we have had. The starved individual lives largely on his fat if he is well nourished when starvation is begun. If he is lean, he is thrown back on his body protein for energy, and the result is an increased protein metabolism with an increased liberation of glucose to the circulation to the extent of 58 per cent. of the metabolized protein. It seems to me that that is an adequate explanation of the fact that diabetics of the severe type who are all undernourished and are thrown back on their protein for calories often do not become sugar-free when starved. Once they are given fat they are supplied with energy in a form from which little or no sugar is derived. Of these 116 patients treated in the same period as Dr. Joslin's group we have had two under 10, seven under 20, seventeen under 30, and fifteen under 40, so that we have had a fair proportion of the juvenile type of diabetes. Not included in this tabulation are a number of children from 3 to 6 year of age who were treated by Dr. Cowie on the same plan with the same results. Hence, we have had children and young individuals in large numbers.

The Fate of Arsenic After Its Intravenous and Intrathecal Injection

DRS. R. D. RUDOLF and F. M. R. BULMER, Toronto: By the use of very delicate technic, based on the Gutzeit method, we noted that the percentage of arsenic in the blood, estimated one hour after intravenous administration, rises in proportion to the dose given, and the same relation holds good in regard to the liver; but we have been unable to demonstrate any arsenic in the spinal cord even on increasing the intravenous dose nine times (to an amount sufficient to produce profound degenerative changes in the liver). The Swift-Ellis method was tried in many animals, and still the cord remained free from arsenic. If arsenic is injected intrathecally in massive doses under pressure, it undoubtedly enters the spinal cord and will produce there nerve destruction with ascending paralysis and later death; but when small amounts are used (such as have been employed therapeutically), no such entry can be demonstrated.

The Value of Vital Capacity Determinations in the Diagnosis and Treatment of Heart Disease

DR. JOSEPH H. PRATT, Boston: The vital capacity determination is of aid in the diagnosis of organic heart disease. In 100 persons with normal hearts, the mean vital capacity was between 3,500 and 4,000, while in 100 cases of heart disease it was between 1,500 and 2,000. With increase of cardiac weakness, the vital capacity falls rapidly. A drop in the vital capacity may precede other symptoms and signs of cardiac insufficiency and serve as a valuable warning. A chart of the vital capacity reading over the period of treatment often gives the best and most convincing record of the progress of a case. In a case of acute rheumatic myocarditis the vital capacity fell to 1,000 and slowly rose to 3,500 during five months of strict rest treatment. Graduated exercise was rarely followed by a rise in vital capacity. In cases of regular heart action, increased by two weeks' rest in bed, digitalis produced no further increase.

(To be continued)

Current Medical Literature

AMERICAN

Titles marked with an asterisk (*) are abstracted below.

Archives of Surgery, Chicago

May, 1922, 4, No. 3

*Review and Classification of Bone Sarcomas. J. Ewing, New York.—p. 485.
Generalized Type of Osteitis Fibrosa Cystica. J. J. Morton, New Haven, Conn.—p. 534.
*Acute Hematogenous Osteomyelitis. C. L. Starr, Toronto, Can.—p. 567.
Open Pneumothorax in Its Relation to Extirpation of Tumors of Bony Chest Wall. C. A. Hedblom, Rochester, Minn.—p. 588.
*Fracture-Dislocation of Spine. R. A. Hibbs, New York.—p. 598.
*Carcinoma of Lung. M. Barron, Minneapolis.—p. 624.
*Comparative Results of Ligation of Hepatic Artery in Animals. M. Behrend, H. E. Radasch, Philadelphia, and A. G. Kershner, Norristown, Pa.—p. 661.
*Inguinal Hernia: Study of Principles Involved in Surgical Treatment. P. W. Harrison, Bahrein, Persia.—p. 680.
*Unusual Case of Intestinal Obstruction. A. M. Willis, Richmond, Va.—p. 690.
Seventeenth Report of Progress in Orthopedic Surgery. R. B. Osgood, R. Soutter, H. C. Low, M. S. Danforth, L. T. Brown and P. D. Wilson, Boston.—p. 693.

Bone Sarcoma.—The forms of neoplastic diseases originating in bone and bone marrow are classified by Ewing as follows: Osteoma: spongy, ivory. Chondroma: pure chondroma, chondromyxoma. Myxoma: capsular, periosteal, central. Angioma: cavernous. Endothelioma: angio-endothelioma, diffuse: solitary, multiple. Benign central giant cell tumor and its variants: bone cyst, giant cell tumor, xanthosarcoma, myxosarcoma (benign). Osteogenic sarcoma: Periosteal (extraperiosteal), solid medullary and subperiosteal, telangiectatic, sclerosing. Myeloma: plasma cell, lymphocytic, myelocytic, erythroblastic. The existence of telangiectatic osteogenic sarcoma as a distinct disease has not yet gained general acceptance; however, Ewing is convinced that this lesion is one of the most specific of bone tumors, both in its gross anatomy and in its clinical course. One type of malignant bone aneurysm is a vascular osteogenic sarcoma. Its possible relation to cavernous angioma must be considered. In spite of recent contributions to the contrary Ewing believes that the existence of four specific types of myeloma is firmly established. The knowledge of endothelioma of bone has reached a stage which calls for definite recognition of this disease. The condition is generally submerged under the general diagnosis of round cell sarcoma or myeloma, since both are composed of small diffusely growing cells with round nuclei. Ten cases have come to Ewing's notice within the past year. These various varieties of malignant bone tumors are discussed in detail both as to their pathology and their treatment.

Acute Hematogenous Osteomyelitis.—The diagnosis being made early, Starr says, treatment should consist of incision over the area of greatest tenderness, through the skin, subcutaneous tissue and periosteum to the bone. Care should be exercised to keep the incision clearly on the diaphyseal side of the epiphysis to preserve the periosteal attachment to the epiphyseal line. This safeguards to a large extent the possibility of extension to the joint. If frank pus is encountered, this incision is sufficient, if a drain is kept in for a time. If no gross pus is encountered, the periosteum is stripped for a short distance on either side of the incision, to be sure that the incision is not in the wrong place. If still no frank pus is seen, a series of possibly three drill holes is made from the cortex, obliquely downward toward the epiphyseal line. These are about one-fourth of an inch apart up the cortex, and extend at least into the center of the shaft at the epiphyseal line, as shown in the diagram. The treatment usually advocated of trephining an opening into the medullary canal, 2½ inches or more up the shaft, Starr says, seems to be pernicious. If the periosteum is opened and holes drilled into the shaft at the metaphysis, one can hope to relieve the symptoms and prevent necrosis sufficient to produce sequestration. In the later stages the plan of treatment adopted by Starr is this: After efficient drainage has been established, operation is delayed until the sequestrum is separated. Then a channel sufficiently large to remove the sequestrum is chiseled through the involucrum; the cavity is gently curetted until it is free of dirty granulations; the cavity is sponged with iodin, and packed tightly for forty-eight hours with iodoform gauze, after which all packing and drains are removed. If the cavity left is too large to fill easily by granulation, the edges are made saucer-shaped, or flattened, to permit the soft tissues and periosteum to fall in and obliterate it. The practice of attempting to chisel away necrotic bone before it has delimited itself is condemned, as it is impossible to determine where the necrotic bone ends and where the living bone begins. Living bone is thus either taken away or necrotic bone left. The blind curetting of a bone where there may or may not be a sequestrum is not a procedure which is likely to produce any beneficial results. Sequestrotomy should be performed in a bloodless field, using a tourniquet wherever it can be safely used. Ill-considered and incomplete operations in the latter stage are largely responsible for the fact that in so many of these bone cases discharging sinuses continue for years, and the patients are subjected to operations without number.

Fracture-Dislocation of Spine.—Of the twenty-two cases of fracture-dislocation of the spine reported by Hibbs one was in the cervical region, two were in the dorsal region, two in the dorsolumbar region, and seventeen in the lumbar region. Of the last named, eleven were of the fifth lumbar vertebra. There was a definite history of severe traumatism in the cervical case, in the two dorsal cases, in the two dorsolumbar cases, and in twelve of the lumbar cases. In five of the last, the injury had occurred in childhood. The symptoms in three cases, except those of short duration occurring immediately after the injury, did not appear until adult life when ossification of the vertebrae was complete. In one case there was a history of slight injury, and in four cases no history of injury. Four patients with displacement of the fifth lumbar vertebra had imperfect first sacral arches. In each the fusion was made to include at least one healthy vertebra above and one below the injured vertebra. The patient was kept in bed for eight weeks and required to wear a support for from two to four months longer. The support in each instance was of the Taylor spine brace model, except in the lumbar cases, when it was shortened above to extend only to the tip of the scapula, and lengthened below to grasp the pelvis. The result in virtually all cases was complete relief from symptoms with resumption of usual activities.

Carcinoma of Lung.—The study of the thirteen cases reported by Barron shows the importance of assuming a new attitude toward this disease with reference to its prevalence and diagnosability. Two cases encountered during the past year were both recognized clinically; but ten of the remaining eleven of this series were not diagnosed correctly. This fact points strongly to the necessity of greater familiarity with the signs, symptoms and pathology of the disease.

Results of Ligation of Hepatic Artery.—Ligation of the hepatic artery is dangerous at all times. This has been proved in the few cases reported in which a deliberate ligation in man was one of necessity on account of aneurysm or other pathologic conditions. Only one patient recovered. Rabbits and guinea-pigs always succumb to successful peripheral ligation. Dogs and cats resist the ligation and continue to live indefinitely in spite of a combination of a peripheral and central ligation. An important point to be kept in mind is that histologically degeneration of the liver cells has been found in all animals in which ligation was performed.

Operation for Inguinal Hernia.—In the operation used by Harrison for inguinal hernia an effort is made to repair and strengthen the transversalis fascia. Local anesthesia is used (procain and epinephrin), except in small children. Silk is used for suture material. The external oblique fascia is split in the direction of its fibers, up from the external ring as far as seems indicated. The peritoneum is grasped high up, next to the internal oblique muscle, and its isolation is carried to the level of the public bone. At this point, the sac is opened,

the intestines are replaced in the abdomen, if necessary, and the neck of the sac is reinjected with anesthetic solution from within, as high up as desired. The neck of the sac is then completely isolated from surrounding structures, and the sac is amputated. No effort is made to dissect the sac out and remove it, except in unusual cases. The dissection of the neck of the sac is then carried very high up. A dissection which does not demonstrate the deep epigastric vessels, Harrison regards as insufficient. The second part of the operation, namely the repair, is begun by dividing the neck of the sac into an upper and a lower leaf, by means of two lateral divisions. The lines of division are carried down on each side, well to the limit of the dissection. The lower leaf is then carried up inside the abdomen for an inch, or more, to the limit of the operative field, pulled fairly taut, and sutured into place. The upper leaf is carried down, overlapping the lower, and sutured to the lowest point that the dissection makes available. The overlap should amount to at least 1 inch, or 1½ inches. Following this, the cremaster is sutured under the internal oblique muscle and the conjoined tendon, thus making the repair snug and efficient. Harrison makes it a rule to test the operative repair at this point by having the patient cough violently and strain. The external oblique muscle is repaired, restoring the external ring, which is left more or less normal in size.

Sacculation of Ileum Causes Intestinal Obstruction.—Willis cites the case of a boy, aged 11, who was suddenly seized with severe, generalized abdominal pain. He soon became nauseated and vomited steadily for two hours. At the end of this time, the pain gradually subsided and soon ceased entirely. There was no recurrence of the pain for four days, when a similar attack occurred. Examination at this time revealed an oblong mass, about 4 inches long, in the right lower quadrant of the abdomen. The pain diminished, but some pain persisted until the following day. A provisional diagnosis was made of partial obstruction from appendiceal abscess, though the possibility of intussusception was borne in mind. Three days later the abdomen was opened. It was seen that the mass was due to a enlargement of the lower portion of the ileum, above the ileocecal junction, the enlargement suggesting strongly the presence of an intussusception of this portion of the bowel. The mass lay entirely in the pelvis. It was about 6 inches long and 3 inches across, somewhat ovoid in shape. The covering resembled the visceral peritoneum, except that it was somewhat paler. It proved to be a sac, formed from a membrane which appeared to cover the whole of the small intestine. Above and below the sacculated portion, this membrane was quite closely approximated to the intestine, somewhat like a loosely fitting glove finger. This sheath could be slipped about an inch in either direction, downward or upward; further movement was then prevented. The sacculated portion was split longitudinally, in the direction of the mesentery, and it was found that within the sac there were 30 inches of small intestine, much coiled and folded, the terminal portion showing multiple diverticula. There were no adhesions between the adjacent coils of intestine; but a few delicate strands of connective tissue ran from the intestine to the inner surface of the sac. It was apparent that the cause of the recurring attacks was a displacement of the mass of intestine contained in the sac. When this mass was fitted down into the pelvis, it caused no symptoms; when it was displaced upward, it caused an angulation of the intestine and the consequent obstruction. The absence of any evidence of an inflammatory process indicates that the condition was the result of some developmental defect.

Boston Medical and Surgical Journal

May 18, 1922, **186**, No. 20

*Leukemia and Severe Anemia in Childhood. J. L. Morse, Boston.—p. 657.
Report of Progress in Orthopedic Surgery. M. N. Smith-Petersen, Boston.—p. 665.
Speech Development in Crippled Children. - Report of One Hundred and Two Cases. C. G. Stivers, Los Angles.—p. 669.
Aleppo Boil; Also Called Delphi Boil, Kandahar Sore, Oriental Sore. A. K. Yousuf, Worcester, Mass.—p. 675.
The National Health Council. D. B. Armstrong and J. A. Tobey, Washington, D. C.—p. 677.

Leukemia and Severe Anemia in Childhood.—Among thirty-seven cases of leukemia and severe anemia in childhood seen by Morse, myelogenous leukemia was encountered but once, in a boy, aged 4 years. He died unexpectedly before the blood was examined. The liver and spleen showed the characteristic changes of myelogenic leukemia. There were twelve cases of undoubted lymphatic leukemia in which the mononuclear cells numbered at least 50,000, in most instances being in hundreds of thousands. The patients were from 2 to 13 years of age. In one instance in which the blood was examined and found normal before the development of scarlet fever in the hospital, leukemia developed during convalescence and ran its course in three weeks. In another instance the onset apparently followed a fall. In the other cases there was no apparent etiology. There were eighteen cases of severe anemia with moderate or low white counts, but with a high percentage of mononuclear cells. All the patients died. The duration of the disease varied between two weeks and six months. In one instance, the onset of the illness was immediately after an attack of measles, in another it followed an operation for the removal of tonsils and adenoids, and in another a fall on the head. In one case it was thought to have developed after an attack of malaria, but no plasmodia could be found in the blood. In another case there was a possible connection with an abscessed tooth, but there was no improvement after the tooth was removed. In the other cases there was no apparent etiology.

Journal of Nervous and Mental Disease, New York

April, 1922, **55**, No. 4

*Delirium Acutum and Primary Sinus Thrombosis. K. H. Bouman and B. Brouwer, Amsterdam, Holland.—p. 273.
Pachymeningitis Cervicalis (Syphilitic) with Unusual Features. M. Keschner, New York.—p. 294.

Delirium Acutum and Primary Sinus Thrombosis.—Two cases are described by Bouman and Brouwer which occurred in persons suffering from manic depressive psychosis. In the postmortem examination a primary sinus thrombosis was found which proved to be of recent date and was not the cause of the delirium acutum. Both affections were the consequence of a general infection of the body. There was extensive degeneration in the nerve cells. The lesion was most severe in the frontal area of the brain and the larger cells showed more inclination to suffer than the smaller cells.

Journal of Radiology, Omaha

May, 1922, **3**, No. 5

*Errors in Roentgenologic Diagnosis of Duodenal Ulcer. R. D. Carman, Rochester, Minn.—p. 163.
Practical Applications of Ionization Measurements of Roentgen Rays. A. W. Erskine, Cedar Rapids, Ia.—p. 169.
*Treatment of Malignant Neoplasms of Tonsils. D. Quick, New York.—p. 173.
Fractures of Carpal Scaphoid. A. M. Pfeffer, Baltimore.—p. 179.

Errors in Roentgenologic Diagnosis of Duodenal Ulcer.—The principal causes of affirmative error in the diagnosis of duodenal ulcer, in the order of their importance, Carman says, are reflex spasm, periduodenal adhesions and gastric lesions near the pylorus. Duodenal spasm from extrinsic causes is most often associated with cholecystitis or chronic appendicitis. Juxtapyloric gastric lesions may implicate the duodenal bulb or alter land marks so that exact diagnosis may be difficult. Tumors of the duodenum, either benign or malignant, and diverticula are rare sources of error. Confusion of the bulbar shadow with that of other parts of the duodenum or with the shadows of adjacent concretions is a technical fault which can usually be avoided. The percentage of negative errors in this series slightly exceeds the percentage of affirmative mistakes. Many of these diagnostic failures are explainable by the absence of bulbar deformity, either organic or spastic. Failure to diagnose a duodenal ulcer associated with a demonstrable gastric ulcer is not a grave oversight. Ulcers situated beyond the bulb can hardly be diagnosed as such, although obstruction may be demonstrable. They constitute a very small percentage of the total. Many negative errors are avoidable. Some of them are due to technical faults, others are solely the result of

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careless observation and are indefensible. Perfection is admittedly unattainable, but the roentgenologist should not criticize himself too charitably.

Radium Treatment of Malignant Neoplasm of Tonsils.—During the past five years Quick has treated 149 cases of malignant neoplasms of the tonsil with radium. Of 124 cases of carcinoma of the tonsil, twenty-eight are now clinically free from disease. Two other cases were free from clinical evidence of disease for fifteen months, at which time they were lost track of. Twenty cases at present under treatment are progressing favorably and a fair number at least bear promise of a complete clinical regression. Forty-one patients were definitely improved for varying periods of time, but finally either died of the disease or are steadily becoming worse. Twenty-seven patients were absolutely unimproved by treatment and ten more were completely lost track of, so that they must be classified with those totally unimproved. Of the carcinomas, ten were recurrent cases, two of which were with recurrent cervical nodes and an unrecognized primary lesion in the tonsil. Twenty-four cases belonged to the group of lymphosarcomas or malignant granulomas. Of this group six cases are now free from clinical evidence of disease. One shows an excellent palliative result of over three years' duration, but at no time has he been entirely free from clinical evidence of disease. Six of these cases were recurrent. One case of rhinoscleroma of the tonsil has been under treatment for over three years, at times showing an apparent complete regression, only to reappear in some adjacent area of mucosa. Of the twenty-eight cases of carcinoma of the tonsil reported clinically free from disease at present, the average duration since the initial treatment is twenty-six months. The longest period is fifty-six months and the most recent four months. In ten cases, neck operations were performed and in these the average duration is twenty-eight months. The oldest is fifty-six months and the most recent six months. Quick states that best results can only be obtained in these cases by interstitial radiation—either by means of radium emanation or lightly filtered needles containing radium element embedded in the growth. This should be supplemented by heavily filtered external radiation—either roentgen rays or radium. The treatment of cervical metastases of carcinoma of the tonsil is best managed by a combination of radium, roentgen ray and conservative surgery. In lymphosarcoma or the malignant granulomas of the tonsil, surgery plays no part whatever. Metastases to the cervical nodes or elsewhere should be managed entirely by a combination of radium and roentgen rays.

Journal of Urology, Baltimore

May, 1922, 7, No. 5

*New Method of Perineal Prostatectomy Which Insures More Perfect Functional Results. J. T. Geraghty.—p. 339.
Diverticula of Bladder. Report of Cases. A. H. Crosbie, Boston.—p. 353.
*Sphincterotomy Per Urethram. Simple and Safe Procedure for Cure of Contracture of Vesical Orifice. J. T. Geraghty, Baltimore.—p. 367.
*Structural Basis for Congenital Valve Formation in Posterior Urethra. E. M. Watson, Buffalo.—p. 371.
*Bone Metastasis from Primary Carcinoma of Urinary Bladder. H. G. Wells, Chicago.—p. 383.
*Cure of Prostatic Abscess by Aspiration. B. S. Barringer.—p. 397.
Case of Prostatic Infection Complicated by Osteomyelitis. J. Pedersen, New York.—p. 405.
*Physiologic and Pharmacologic Studies of Prostate. IV. Response of Prostatic Muscle to Drugs. D. I. Macht.—p. 407.

New Perineal Prostatectomy.—The operation described by Geraghty differs essentially from the technic described by Young in that the membranous urethra is not exposed or at any time in the field of operation. Its intrinsic and extrinsic musculature, as well as the nerve supply, are neither disturbed nor injured.

Sphincterotomy Per Urethram.—The instrument employed by Geraghty for dividing the sphincter consists of a wedge-shaped concave knife which accurately fits a F 28 endoscopic tube similar to the outer sheath of the Young punch. The anterior and posterior urethra are anesthetized with a 4 per cent. procain solution and the bladder filled with 200 c.c. of water, if possible. The sheath with its obturator is passed, after which the latter is withdrawn. After the removal of the obturator the sheath is withdrawn until fluid ceases to escape which indicates that the fenestrum has engaged the vesical orifice. In rare instances in which the trigone is markedly hypertrophied the ligamentum interureteric um may engage the fenestrum. This may be readily recognized by rotating the instrument 90 degrees when water will begin to escape unless the fenestrum lies at the level of the orifice. The vesical orifice now being engaged in the fenestrum, the knife is introduced and the fibrotic ring divided. In cases in which it is desirable to incise deeply, especially when the fibrosis is unusually thick, a forked spear lifts the fibrous ring into the fenestrum. While the spear mobilizes the tissue to be incised the knife is then passed and a deeper cut obtained.

Origin of Congenital Valve Formation in Posterior Urethra.—Watson states that the so-called valves or congenital strictures of the prostatic urethra may have their origin as early as the fourteen weeks of fetal life, at which time there were present in the specimens studied no associated secondary sequels such as the dilated posterior urethra, dilated trabeculated bladder with hydroureters and hydronephrosis as is usually found in the latter pictures of this condition. The valve formation is due to the growth and attachment of the tip of the colliculus to the roof of the urethra and occurs at the time of marked epithelial activity of this and associated parts, namely, the invagination of the verul mucosa to form the first observed tubules of the verumontanum.

Bone Metastases from Bladder Cancer.—In five cases of carcinoma of the bladder in which Wells performed a necropsy none showed any metastasis. In another case a comparatively small carcinoma of the urinary bladder gave rise to a remarkably large secondary tumor of the sternum, metastases in left axillary lymph glands, left lung, right kidney and liver; also in right first and fourth and left first and fifth ribs and right ilium. The absence of any mention of symptoms referable to the bladder was notable in this case. While he was in the hospital there was frequency of urination. The urine was reported as containing albumen but no casts or cells, although alkaline in reaction. It was recorded that the protein was not of the Bence-Jones type. Examination revealed no physical changes of importance except for a great symmetrical rounded swelling on the anterior chest wall, hard, not pulsating and without murmurs. The lungs and heart showed no noteworthy abnormalities, beyond pulmonary emphysema. There was a bilateral hydrocele. A specimen of blood examined by the Abderhalden method gave a positive reaction with carcinoma substrate. After the patient was in the hospital a few days he became delirious, gradually grew weaker, dyspnea developed and he died. A detailed necropsy report is given by Wells.

Treatment of Prostatic Abscess by Aspiration.—Fifteen patients have been saved general anesthesia, perineal section, damage to the prostatic urethra and long convalescence by aspirating pus from the prostate by the needle method described by Barringer. No untoward results have followed this method, and no patients have had to be operated on subsequent to the aspiration. Experience has indicated that the method should be restricted to gonococcus infections. Abscesses of the prostate caused by streptococcus, staphylococcus or colon bacilli do not do well after aspiration. The method should not be used when the abscess has broken through the capsule of the prostate and is pointing in the ischiorectal fossa or has extended toward the seminal vesicles. Here operation is indicated.

Response of Prostatic Muscle to Drugs.—The effects of various drugs were studied by Macht on strips of surviving excised prostate glands of different animals. The preparations responded promptly with contraction to barium chlorid and with relaxation to papaverin hydrochlorid, thus indicating the presence of muscle tissue. The preparations responded distinctly to treatment with epinephrin and ergotoxin but failed to respond (with the exception of the rabbit's prostate) to treatment with pilocarpin, physostigmin, muscarin and atropin. These observations speak in favor of a true sympathetic innervation of the prostate gland.

Kansas Medical Society Journal, Topeka

May, 1922, **22**, No. 5

Whooping Cough. R. L. Von Trebra, Chetopa.—p. 133.
Pulmonary Abscess and Its Surgical Treatment. R. B. Stewart, Topeka. —p. 135.
Epidemic Encephalitis: Summary of Present Knowledge. K. A. Menninger, Topeka.—p. 139.
Hexamethlenamin: Its Use and Misuse. A. G. Dumas, Osawatomie.—p. 146.

Minnesota Medicine, St. Paul

May, 1922, **5**, No. 5

Herpes Cornea. E. Boeckmann, St. Paul.—p. 277.
Progress in Urology. W. F. Braasch, Rochester, Minn.—p. 286.
Treatment of Duodenal and Gastric Ulcers. A. C. Strachauer, Minneapolis.—p. 290.
Common Conditions Simulating Pulmonary Tuberculosis. F. W. Spicer, Duluth.—p. 295.
Maxillary Sinusitis of Dental Origin. K. A. Phelps, Minneapolis.—p. 299.
Heliotherapy. J. H. Bendes, Oak Terrace.—p. 302.
Complications Following Surgery of Gallbladder and Bile Ducts. W. C. Carroll, St. Paul.—p. 307.
Blastomycosis: Clinical Pathology and Therapeusis. B. F. Davis, Duluth.—p. 311.
Pyelitis. A. E. Sohmer, Mankato.—p. 316.

New Orleans Medical and Surgical Journal

May, 1922, **74**, No. 11

Pituitrin in Obstetrics. C. H. Cleveland, Anniston, Ala.—p. 700.
Problems to be Solved by Medical Profession in Co-Operation with Public. J. E. Knighton.—p. 704.
Tropical Diseases. L. Ambrose, New Orleans.—p. 717.

U. S. Naval Medical Bulletin, Washington, D. C.

Hospital Corps Quarterly

April, 1922, **6**, No. 2

Old and New Hospital Corps. C. F. Wood.—p. 1.
Modern General Anesthesia. J. G. Poe, Dallas, Tex.—p. 5.
Possible Simple Method to Determine Presence of Foreign Fat in Butter Fat. J. C. Fagan.—p. 11.
Mushrooms and Toadstools. E. H. Winston.—p. 16.
Good Old Days. S. J. Kinkaid.—p. 18.
Tenth Revision of United States Pharmacopeia. E. F. Cook.—p. 33.
Hospital Corpsman's Field. F. Doty.—p. 43.
Equipment for Base Hospital of 1,000 Beds Capacity. T. J. Murphy.—p. 48.

FOREIGN

An asterisk (*) before a title indicates that the article is abstracted below. Single case reports and trials of new drugs are usually omitted.

Archives of Radiology and Electrotherapy, London

April, 1922, No. 261

Radiology and Physics. G. W. C. Kaye.—p. 336.
*Foreign Body in Duodenum. G. Vilvandre.—p. 349.
Two Cases of Idiopathic Dilatation of Colon in Adults. R. M. Beath. —p. 350.
Selection of Gamma Rays or Roentgen Rays for Radiotherapeutic Purposes. W. S. Lazarus-Barlow.—p. 355.

Foreign Body in Duodenum.—A nail swallowed by a mentally unstable woman, aged 57, remained in the second portion of the duodenum for at least three days before its removal; and in spite of its sharp end and inability to enter the third stage of the duodenum, did not perforate the intestine. A large safety pin was also ingested, but being closed and of more rounded contour gradually passed through and caused no trouble.

British Journal of Experimental Pathology, London

April, 1922, **3**, No. 2

*Effect on Arterial Hypertension of Increased Fluid Intake. J. B. Orr and I. Innes.—p. 61.
Details of Technic Adopted in Following Weigl's Plan of Feeding Lice Infected with Virus of Typhus Fever by Rectal Injection. A. W. Bacot.—p. 72.
Poisonous Properties of Colloidal Silica. I: Effects of Parenteral Administration of Large Doses. W. E. Gye and W. J. Purdy.—p. 75.
Poisonous Properties of Colloidal Silica. II: Effects of Repeated Intravenous Injections on Rabbits; Fibrosis of Liver. W. E. Gye and W. J. Purdy.—p. 86.
*Association of Virus of Typhus Fever with Various Blood Elements. J. Segal.—p. 95.
Anoxemia and Increased Electrical Excitability of Neuro-Myone. N. Morris.—p. 101.

Effect of Increased Fluid Intake on Arterial Hypertension.—Orr and Innes report on an investigation on the influence of increased water ingestion on the blood pressure of some apparently normal subjects and also of persons with high arterial tension. The addition of from 2 to 3 liters of water to the normal daily consumption is followed by a distinct fall in both systolic and diastolic pressures. The fall is not accompanied by an increase of either the rate or force of the heart beat, and the decreased pressure is maintained for some time after the extra water has been excreted. Reasons are put forward in support of the suggestion that the chief factor in producing the fall of pressure is the elimination of pressor substances that cause arterial constriction and thereby produce an unnecessarily augmented arterial tension. When diuresis is unable to keep pace with the intake of water, especially in cases of high arterial tension, the fall in pressure is sometimes preceded by a rise beyond the original level, which persists until the bulk of the extra fluid has been eliminated.

Virus of Typhus Carried by Blood Platelets.—According to Segal leukocytes obtained from peritoneal exudates of typhus infected guinea-pigs do not carry the virus. The virus seems to be intimately connected with the platelets. By the separation of these cells from a large quantity of blood a high concentration of virus can be obtained for experimental purposes.

Journal of Laryngology and Otology, Edinburgh

May, 1922, **37**, No. 5

Saccular, Utricular and Allied Reflexes. A. R. Tweedie.—p. 213.
Epithelial Inlay in Radical Mastoid Operations. E. H. White.—p. 223.
Diagnostic Value of Transillumination of Maxillary Antra. E. Watson-Williams.—p. 227.
*Influence of Oral Sepsis on Course of Cancer of Throat. D. M'Kenzie. —p. 230.
Intranasal Dacryocystostomy: Easy Method of Approach. A. Campbell. —p. 232.
Instrument for Measuring "Bridge" in Mastoid Operation. T. B. Jobson.—p. 233.

Influence of Oral Sepsis on Course of Throat Cancer.—It occurred to M'Kenzie that in a small group of cases of untreated throat cancer the progress of the disease is curiously slow. Examination showed that the slow cases were in people who were edentulous, and who had been edentulous before the symptoms of cancer appeared; while, on the other hand, in the ordinary, or what may be called the septic class, teeth were still present in the mouth. It does not seem to matter whether the teeth be few or many. M'Kenzie suggests that when all the teeth have been removed the mouth secretions are much less virulently infective than when the teeth are present, and that the progress of the cancerous growth is rendered slow or rapid in consequence of this very simple circumstance. Another point which favors his suggestion is that many, if not most, patients with throat cancers die not of hemorrhage, nor of asphyxia or starvation, but of septicemia. The cervical glands enlarge rapidly and break down, while the patient succumbs with all the signs of severe septic intoxication.

Journal of State Medicine, London

April, 1922, **30**, No. 4

*Cultural Characteristics and Virulence of Mammalian Tubercle Bacilli and Circumstances Under Which They May Vary. A. S. Griffith.—p. 139.
Role of Three Types of Tubercle Bacilli in Human and Animal Tuberculosis. L. Cobbett.—p. 160.

Study of Mammalian Tubercle Bacilli.—Griffith discusses the properties of the standard strains of each type of tubercle bacilli, the experimental variations, and the variants which occur in nature. Griffith considers that the bovine tubercle bacillus is at least as virulent for man as is the human tubercle bacillus. The bovine tubercle bacillus is less frequently than the human tubercle bacillus associated with the severe and fatal forms of human tuberculosis, but this is because the bovine tubercle bacillus invades the body almost exclusively by way of the alimentary tract, whereas the human tubercle bacillus gains access mainly by the channel of the respiratory passages. Hence, cases of primary intrathoracic tuberculosis due to the bovine tubercle bacillus are extremely rare, and there are very few cases of primary abdominal tuberculosis due to the human tubercle bacillus

which do not also show evidence of concurrent infection via the respiratory tract. Of the two modes of infection, ingestion is much less certain and sereve in its effects than inhalation. Although the bovine tubercle bacillus has the more difficult channel of entry, nevertheless it is able to produce all the chief varieties of human tuberculosis, including ulcerative pulmonary tuberculosis, and in children is often the cause of severe and rapidly fatal general tuberculosis. When cases of tuberculosis which are usually not fatal, e. g., lupus, bone and joint tuberculosis, are considered, there is not any clinical difference indicating that bovine tubercle bacilli produce a less severe form of disease than human tubercle bacilli.

Lancet, London

May 13, 1922, **1**, No. 5150

Endocrine Insufficiency and Chronic Intestinal Disease. F. J. Sadler.—p. 929.
Modern Methods of Research in Cardiology. I. Harris.—p. 931.
*Adrenalin in Stokes-Adams Syndrome. A. G. Phear and J. Parkinson.—p. 933.
Suction Difficulties of Young Infants. H. C. Cameron.—p. 936.
Studies from Royal Mineral Water Hospital, Bath. J. M. H. Munro.—p. 938.
*Some Uncommon Abdominal Emergencies. H. W. L. Molesworth.—p. 943.
*Case of Congenital Pyloric Stenosis. R. E. Smith.—p. 944.
Case of Renal Dwarfism. D. Paterson.—p. 944.

Epinephrin in Stokes-Adams Syndrome.—In a woman of 49 with complete heart block, who was under observation for seven days and nights, severe Stokes-Adams attacks were recurring almost every minute. The subcutaneous injection of epinephrin was followed by complete cessation of the attacks within fifteen minutes. While it seems probable that only in isolated cases will such a beneficial effect be obtained Phear and Parkinson urge that a trial should be made of a subcutaneous injection of 5 minims (0.3 c.c.) of epinephrin (1:1,000), and if this fails, larger doses of from 10:30 minims should be used.

Abdominal Emergencies; Henoch's Purpura; Perforating Ovarian Dermoid.—Molesworth reports a case of Henoch's purpura in which the abdominal symptoms led to a preoperative diagnosis of perforated appendix. A case of sudden severe abdominal pain with repeated vomiting proved to be a right ovarian dermoid cyst with a perforation one-fourth inch in diameter exuding pus and hair. This was removed and the abdomen dry-mopped and drained. In another case of abdominal pain of an intermittent character with vomiting a rounded oval tumor situated centrally in the abdomen with its long axis vertical slightly movable, led to a preoperative diagnosis of intussusception. Laparotomy showed that the tumor was retroperitoneal presenting through the mesosigmoid. It was an enlarged ectopic left kidney. The specimen was a hydronephrosis due to congenital stricture at the ureteropelvic junction. A man, aged 55, had sudden severe abdominal pain, constipation and vomiting. The abdomen was slightly distended. Just above the right internal abdominal ring was an elusive rounded lump; but while its characters were being sought it slipped away. Diagnosis was intestinal obstruction due to unknown cause. On opening the abdomen the lump was found to be in the small intestine about a foot from the ileocecal valve. It proved to be two thirds of an orange complete with its skin, rolled into an ellipse rather like a shark's egg. Three days later he had another attack of abdominal pain, vomiting, and constipation. Preparations for a second laparotomy were afoot but quite suddenly he announced that he was better. The following morning he passed the remaining third of the orange rolled into a similar though smaller ellipse.

Incarcerated Appendix Causes Pyloric Stenosis.—A case is recorded by Smith to suggest that an incarcerated appendix in a hernial sac may be one of the factors not only of primary causation but also of continuation of congenital pyloric stenosis. A male infant, aged 3 weeks, was admitted to hospital with all the classical signs and symptoms of congenital pyloric stenosis. The stenosis was of the rarer type, being complete at birth and giving rise to immediate vomiting from the first feeding, associated with absolute constipation and very marked emaciation. A bismuth meal confirmed the completeness of the block and Rammstedt's operation was at once resorted to. Fourteen days after operation a normal stool was obtained. On the sixteenth day, the infant again had severe gastric upset, with alarming vomiting, at first uncontrolled even by a very strict dietary and saline for two days. Circumcision was performed, and again progress was resumed. At the age of 6 months the mother observed a swelling in the right inguinal region, not previously noted by the mother or by the surgeon. Not until the child was 2 years of age was an operation performed. The hernial protrusion, although scrotal, was very slight in bulk and was noted to be thickened and irreducible, very suggestive of the association of a hydrocele of the cord with a hernia. At the operation for radical cure the sac was opened and found to contain a large appendix, 3¾ inches long. It contained a small soft fecal mass about 1 inch from the base. There were no definite adhesions, but the appendix was firmly planted in the sac by a short meso-appendix, the layers of which were part and parcel of the posterior wall of the peritoneal protrusion of the sac. The condition at operation suggested that the appendix was in the sac before birth.

Medical Journal of Australia, Sydney

April 1, 1922, **1**, No. 13

*Complement Fixation Test for Hydatid Disease and Its Clinical Value. N. H. Fairley.—p. 341.
Analysis of Thirty-Three Cases of Hydatid Diseases of Lung. K. D. Fairley.—p. 346.
Death of Fetus in Utero, Missed Labor and Delivery by Cesarean Section. A. H. Hughes.—p. 355.

April 8, 1922, **1**, No. 14

Prevention of Tuberculosis. R. C. Merryweather.—p. 379.
Routine of a Syphilis Clinic. W. J. Beveridge.—p. 382.
Case of Xanthoma Diabeticorum. G. R. Hamilton.—p. 385.

April 15, 1922, **1**, No. 15

Some Aspects of Insanity. J. E. F. McDonald.—p. 399.
Preventive Medicine in Mental Diseases. W. A. T. Lind.—p. 403.
Plague Experiences. R. W. Hornabrook.—p. 408.
Diffuse Cranial Osteomyelitis as Sequel to Nasal Accessory Sinus Suppuration. G. A. D. McArthur.—p. 410.

Complement Fixation Test for Hydatid Diseases.—In the last twelve years, thirty-three patients with hydatid disease of the lung have been admitted to the wards of the Melbourne Hospital. In each case, the diagnosis has been confirmed by the surgeon at operation or by the pathologist. This paper comprises the results of an analysis of the case histories of these patients. In 39.4 per cent. of these thirty-three patients there was evidence of multiple infestation. In four of these cases the cyst was situated in the left lung; in two it was at the apex of the right lung. The affected site in the remaining twenty-seven cases was the lower portion of the right lung. In nine patients the cyst was suppurating, while it had ruptured in thirteen patients. In five of these ruptured cysts there was evidence of secondary infection, while in two the cyst had undergone degeneration. In only nine instances was the condition diagnosed before the onset of any complication. The cyst wall also showed retrogressive changes in two other patients. Degeneration was, therefore, present in four (12.1 per cent.). In four of the five patients who dated their symptoms from a previous attack of pneumonia, secondary infection of the cyst was present, while no such unusual incidence of superadded infection was noted in patients with a previous history of pleurisy. A detailed analysis of the clinical history of these cases is made by Fairley. Ten patients were not subjected to operation. Two of these had suppurating cysts and both died. In the other eight the cyst had ruptured and roentgen-ray examination or exploratory needling disclosed nothing grossly abnormal. These all progressed satisfactorily. One partially ruptured degenerated cyst was aspirated with excellent result. The remaining twenty-two patients were operated on and two died. In one the cyst was uncomplicated, while in the other suppuration had occurred. One degenerating cyst was successfully closed without drainage, but another similar case closed without drainage had to be reopened and drained. In the other twenty cases the cysts were all drained, the operation being done in nearly every instance at one sitting.

Archives Franco-Belges de Chirurgie, Brussels

February, 1922, 25, No. 5

*Aneurysm of Internal Carotid. G. Cannuyt.—p. 399.
*Osteoma Involving Four Facial Sinuses. C. Goris.—p. 411.
*Trauma of Maxillary Sinus. M. Le Jemtel and F. Rousseau.—p. 417.
Fracture of Maxillary Sinus. J. Moreau.—p. 421.
Extradural Hematoma in Child. H. Mondor.—p. 425.
*The Oscillometer in Surgery. G. Jeanneney.—p. 429.
Congenital Coxa Valga. M. van Neck.—p. 469.
Genu Valgum from Osteomyelitis. M. van Neck.—p. 487.

Aneurysm of Internal Carotid.—Cannuyt encountered a number of cases during the war in which a projectile had injured the ninth, tenth, eleventh and twelfth cranial nerves where they are bunched as they leave the skull. Paralysis of these four nerves from injury at this point is rare in peace times, but he reports here two cases of pure and total paralysis, the result of pressure from an aneurysm in the left internal carotid in a woman of 58 and of a branchioma in a man. Colored plates show the conditions and the differential points.

Giant Osteoma.—The tumor filled the left frontal, ethmoidal, sphenoidal and maxillary sinuses, but was successfully removed. It was as hard as marble, and it took two hours to chip it all out, after tracheotomy. The fragments weighed 320 gm. and the man left the hospital apparently entirely cured the sixth day.

Trauma of Maxillary Sinus.—A long sliver of wood was driven through the nose and maxillary sinus, involving the orbit. After removal of the splinter, visual disturbances for several months were finally cured by covering up the sound eye, although diplopia can still be brought on by looking down toward the right.

Surgical Applications of the Oscillometer.—Jeanneney's illustrated description of the Pachon oscillometer is accompanied by the detailed reports of twenty-eight cases in which the surgeon was materially aided in the diagnosis and operation by this cuff and manometer device with a long needle that wavers at the slightest change in pressure. Among the different types of cases is one of gangrene of the leg in which amputation seemed inevitable, but the oscillometer revealed circulation in the vessels in the depths below the superficial gangrene, and conservative treatment was successfully applied.

Archives de Médecine des Enfants, Paris

April, 1922, 25, No. 4

*Influenza in Children. T. Suzuki.—p. 193. Conc'n No. 5, p. 268.
A Small Epidemic of Diphtheria. J. Camescasse.—p. 215.
*Juvenile Tabes. M. Acuña and J. M. Macera.—p. 224.
*Orchitis in Serum Sickness. F. Carrieu.—p. 230.
Infant Welfare Work in Morocco. J. Comby.—p. 232.

Influenza a Pneumonia.—This study of 1,560 cases in children was made in Manchuria, utilizing the roentgen rays in diagnosis from the first, and supplementing clinical data with experimental research. On this basis, Suzuki asserts that by the second day of the fever the lung shows roentgenoscopic signs of pneumonia although it does not become apparent otherwise until from the third to the tenth day. This hemorrhagic pneumonia is not a complication of the influenza; it is the influenza itself, and the pneumococcus is responsible for it. He always found the pneumococcus from the very first and onward. There were three epidemics of influenza in his region, and the mortality among his child patients was about 9 per cent. Necropsy showed the typical pneumonia even when the clinical picture had been that of meningitis. Rabbits injected with pneumococci isolated from the child cases developed the same hemorrhagic pneumonia by the second day. Forty-six roentgenograms are reproduced.

Juvenile Tabes.—The first symptoms in the boy of 12 with inherited syphilis were swelling and pain in the knees, but this subsided under local treatment. Then followed fracture of the femur and symptoms suggesting tabes during the two years to date. In children, the ataxia and the pains of tabes are not very pronounced, but there may be ocular and bladder disturbances, swelling of joints, and pains in stomach and bladder, besides bone and reflex changes. Under arsphenamin the disease seems to have been arrested in his case; there have been no further visceral crises and the reflexes are livelier, but the cerebrospinal fluid shows no change.

Orchitis During Serum Sickness.—Carrieu ascribes to the serum sickness the orchitis which developed in the boy of 13 after a course of 90 c.c. of diphtheria antitoxin for a mild brief diphtheria. The orchitis had been preceded by a day of fever and an itching eruption, and pain in passively moved joints. The testicles were swollen and painful for nearly six days although the other symptoms of serum sickness soon subsided after 2 gm. of calcium chlorid had been given. Carrieu prescribed, further, 0.5 gm. of quinin plus 0.2 of acetylsalicylic acid.

Bulletin de l'Académie de Médecine, Paris

April 25, 1922, 87, No. 17

Homes for Nursing Mothers. General Discussion.—p. 434. Cont'n.
*Laceration During Labor. A. Le Roy des Barres.—p. 455.
*Theraputic Oleothorax. A. Bernou.—p. 457.

Management of Laceration During Labor.—In des Barres' case there was a slightly contracted pelvis and the maneuvers of the midwife had resulted in laceration of the lower segment of the uterus and vagina, with infection, the child putrefied. He saved the woman by opening the abdomen and protecting the laceration and the peritoneum while the midwife evacuated the uterus by the natural route. After this he removed the uterus. By this means, infection of the peritoneum was kept down to the minimum.

The Oleothorax.—Bernou injects oil into the pleural cavity after evacuation of pus, and in treatment of perforation of the lung in the course of artificial pneumothorax. The normal pleura would not bear this direct treatment, but in such pathologic conditions the oleothorax answered the desired purpose in the two cases described. The fistula healed and the medicated oil prevented adhesions. The oil is rapidly absorbed at first and has to be renewed. In his second case, the pyothorax was secondary to artificial pneumothorax, and after a vomica he aspirated a liter of pus and injected in its place 600 c.c. of oil. Twenty-four days later he withdrew 600 c.c. of pus, replacing it with the same amount of oil, and repeating with smaller amounts as the pus grew less. The oil floats on the pus.

May 2, 1922, 87, No. 18

*Results of Cholecystectomy. H. Hartmann and Petit-Dutaillis.—p. 481.
*Training of Deafmutes. Castex and Thollon.—p. 489.

Remote Results of Cholecystectomy.—This study of 100 persons from one to twenty years after removal of the gall-bladder shows that 92 per cent. were completely cured of their former disturbances. Only 2 per cent. required intervention later on account of adhesions. In another case a calculus in the common bile duct had been overlooked. In 13 per cent. the pathologic appendix had to be removed.

Training of Deafmutes.—Castex calls attention to the great assistance rendered by special cinematographic films in teaching deafmutes to talk.

Bulletins de la Société Médicale des Hôpitaux, Paris

April 7, 1922, 46, No. 13

Autohemotherapy in Dragging Infectious Diseases. F. Ramond.—p. 578.
Radioscopy of Intratracheal Injections. Claisse and Serrand.—p. 579.
Liver Reaction in Serum Sickness. Oudard and Jean.—p. 580.
The Blood During Thorium X Treatment of Chronic Rheumatism. C. Aubertin.—p. 582.
Serotherapy in Acute Pneumonia. D'Oelsnitz et al.—p. 588.
Gangrene of Lung. E. Lenoble and Y. Jegat.—p. 591.
*Emetin in Amebiasis. E. Lenoble and Y. Jegat.—p. 595. Idem. P. Laporte and E. Roques.—p. 603. Idem. V. de Lavergne.—p. 620.
*Intolerance for Arsenicals. Gougerot and Blamoutier.—p. 598.
*Myxedema. Nobécourt and H. Janet.—p. 608.
*Abscess in Lung. G. Paisseau and Ivry-Solomon.—p. 611.
*Artificial Pneumothorax in Child. A. Delille et al.—p. 618.
*Bleeding Time in Purpura. P. Emile-Weil and Bocage.—p. 624.
Vaccine-Serotherapy in Pneumonia. D'Oelsnitz and Colle.—p. 632.
*Compression of Pulmonary Artery. C. Laubry and D. Routier.—p. 636.

Emetin in Amebiasis.—In Lenoble's case the amebic liver abscess showed the benefit from the emetin in twenty-four hours, and the cure soon seemed complete of both the chronic dysentery and the liver abscess. Laporte reports likewise a

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case of old amebic hepatitis, with fever of the undulant type, in which a speedy cure followed emetin treatment. De Lavergne reports four cases of the localization in the rectum of spirochetosis—the fusospirillar infection of Vincent's angina—secondary to amebic dysentery.

Intolerance to Arsenicals.—Gougerot noted a diffuse rash in three syphilitics under arsphenamin treatment, and each of them responded positively with the hemoclastic crisis to ingestion of a glass of milk, fasting. Analysis of the cases demonstrated that the rash is an evidence of intolerance for arsenicals, and they should not be given in any form, as the colloidoclastic shock indicates special susceptibility of the liver. He advises inquiry as to a rash under arsphenamin treatment, as this imposes extra caution, if not forbidding arsphenamin treatment entirely. There was no hemoclastic crisis with mercury or bismuth in his cases, but any arsenical brought it on, and this susceptibility probably persists for years.

Thyroid Treatment in Myxedema.—The basal metabolism in children under thyroid treatment for myxedema showed clearly the effect of the organotherapy. The basal metabolism increased while the weight declined.

Large Abscess of the Lung.—Paisseau emphasizes the ovoid shape of the abscess in the roentgenograms, the large vertical diameter and the regular limitation by a distinct shadow. In two cases reported the large abscess followed pneumonia or a streptococcus bronchopneumonia, and healed spontaneously after a vomica. The gradual subsidence of the cavity could be seen with roentgenoscopy in the young woman and in the man of 49.

Artificial Pneumothorax in Children.—In the case reported, tuberculous meningitis developed after the artificial pneumothorax. The case warns against artificial pneumothorax in children unless only one lung is affected. In this case, lesions in the other lung were probably responsible for the meningitis.

The Bleeding Time in Purpura.—Weil and Bocage refer to cases showing waves of purpura with multiple hemorrhages, a condition to which they have applied the term "hemogenia." They here explain that the tendency to this condition can be recognized by the fluctuations in length of the bleeding time, "an actual arrhythmia of the bleeding time." In the normal, this is stable. They report the application of various tests to explain the nature of the hemogenia and means to influence it, but all with negative results to date.

The Heart as Affected by Pressure on the Pulmonary Artery.—The robust man of 30 died with symptoms of insufficiency of the right heart. Necropsy disclosed that this was of mechanical origin from pressure on the pulmonary artery by a bunch of enlarged mediastinal glands. The artery itself was intact.

Gynécologie et Obstétrique, Paris

April, 1922, 5, No. 4

Pure Fibroma in Ovary plus Uterine Fibroma. Delle Chiaje.—p. 265.
*Hysterectomy Post Abortum. J. Vanverts.—p. 277.
*Fetal Malformations and Syphilis. J. Henrotay.—p. 287.
Circulation in Univitelline Twins. Mutel and Vermelin.—p. 294.
Stenosis of Pylorus in Infants. H. Hartmann.—p. 307.

Hysterectomy Postabortum.—Vanverts relates that in 80 women the fever subsided at once after curetting postabortum; 2 died and the outcome is not known in a third, but improvement had seemed to be progressive. This group included some very serious cases. In another group in which the fever by the next day had kept up the same, or increased, 5 of the 17 women died. In 5 of the 12 cases with recovery, a turpentine fixation abscess had been induced. These experiences confirm the importance of the temperature the day following the curetting as a guide to treatment: with persisting fever the mortality was 29.4 per cent.; with dropping temperature, only 2.5 per cent. With fever persisting the fourth day, the mortality was 55 per cent. Unless the fever can be explained by some extra-uterine lesion, his experience confirms the value of curetting when there is recent retention, not longer than seven days after the abortion, or when the infection is restricted to the uterus. Among the arguments in favor of vaginal hysterectomy in case of persisting fever, or when curetting is impossible, is the empiric observation that on recovery from grave puerperal infection, the lesions and adhesions left in the adnexa prevent normal pregnancies thereafter.

Fetal Malformations and Syphilis.—Henrotay describes among other instances the history of three brothers whose wives were not related and none had ever shown the least sign of syphilis, but two of the wives had borne malformed children or monsters. The retrospective diagnosis showed inherited syphilis in the men, and the third wife was given specific treatment in prophylaxis as she was four months pregnant. A sister of the three men has normal children.

Journal de Chirurgie, Paris

May, 1922, 19, No. 5

*Technic for Duodenojejunostomy. R. Grégoire.—p. 449.
Access to Retrocecal Appendix. P. Lecène.—p. 459.
Removal of Large Inflammatory Abdominal Tumor. R. Dupont.—p. 469.

Duodenojejunostomy.—Grégoire knows of only fifteen published cases of this operation, including his own four cases. His four illustrations show the technic for both the side-to-side and the Y methods, allowing no chance for the vicious circle, and no slit in the mesentery for the bowel to slip through.

Journal de Médecine de Bordeaux

April 10, 1922, 94, No. 7

*Cancer of Jejunum. J. Denis and A. Charrier.—p. 203.
Iodin Internally in Treatment of Tuberculosis. H. Bernard.—p. 205.
Digestion in Hereditary Syphilis in Nurslings. J. Vergely.—p. 206.
Hematuria from Varix in Bladder. H. Blanchot.—p. 211.

Duodenal Occlusion from Cancer.—Denis and Charrier describe a case of duodenal occlusion due to cancer of the jejunum. The syndrome is like that with pyloric stenosis except the extremely profuse vomiting of a green fluid, from 1 to 3 liters daily.

Lyon Médical

April 25, 1922, 131, No. 8

Temporary Tracheostomy for Foreign Bodies. F. J. Collet.—p. 329.
*Pleurisy with Typhoid Fever. A. Dumas and Paupert-Ravault.—p. 332.
Serotherapy and Protein Therapy of Buboes Secondary to Soft Chancre. L. M. Bonnet.—p. 358.

Pleurisy with Typhoid Fever.—Dumas and Paupert-Ravault describe five cases of pleurisy occurring during typhoid fever. One was a typical typhoid pleurisy; two were secondary to bronchopulmonary manifestations, and the other two were probably of a rheumatismal nature. They assumed the rheumatismal nature on account of the conditions under which the pleurisy appeared, the leukocyte count with many endothelial cells, and the accompanying heart and pericardium symptoms and chronic imprint. They applied sodium salicylate treatment at too late a stage of the disease to appreciate its effect, but they will have recourse to it at an earlier stage when similar cases occur again.

Nourrisson, Paris

May, 1922, 10, No. 5

*The Bone Changes in Rachitis. A. B. Marfan.—p. 145.
Acute Vertebral Osteomyelitis in Three Weeks Infant. Madier.—p. 168.
*Exhalation of Water by Infant Lung. Marfan and Dorlencourt.—p. 173.
Acute Dilatation of Stomach in New-Born Infant. J. Péry and P. Balard.—p. 183.
Congenital Stridor with Perilaryngeal Abscess. G. Blechmann and Peignaux.—p. 187.
*Vomiting from Slight Carbon Monoxid Poisoning in Infant. G. Railliet.—p. 191.

The Bones in Rachitis.—Marfan recalls that when rachitis begins before the child is 4 months old, it always starts in the skull; then it affects the ribs, and finally the bones in the limbs; in older children the ribs first, and the arms before the legs. Mild forms are frequently overlooked. Radiography of the wrist is usually instructive, as the bones here are nearly always involved, and the changes are characteristic, as he explains.

Exhalation of Water by Infants' Lungs.—The apparatus described showed that in cholera infantum the amount of water passed off through the lungs was 33 per cent. more than in normal conditions. With ordinary diarrhea, the amount was over 50 per cent. less than usual.

Vomiting from Carbon Monoxid Poisoning.—The young infant's incessant vomiting occurred only in the bedroom; elsewhere it seemed to lose the tendency to vomit. By exclusion, the disturbance was finally traced to a defective chimney. Vomiting is not known as a symptom of coal gas poisoning but this cause was unmistakable here.

Paris Médical

May 6, 1922, **12**, No. 18

*Diseases of Metabolism in 1922. G. Linossier and G. Monod.—p. 361.
*Diabetes in Children. M. Labbé.—p. 371.
Treatment of Grave Diabetes. L. Blum.—p. 378.
Diet in Diabetes. H. Bierry and F. Rathery.—p. 381.
*Obesity in Children. P. Lereboullet.—p. 386.

Diseases of Metabolism in 1922.—Linossier remarks that until recently we have studied diabetes from the urine but now we study it from the blood. His ten page review is devoted to this. He says that the pancreas seems to be the only endocrine gland involved, and that it is involved probably in every case of diabetes.

Diabetes in Children.—Labbé has encountered thirty cases of diabetes in children. It has been observed in infants only a few weeks old. He has never been able to detect any connection with infections or trauma or inherited syphilis. In three instances a family diabetic taint was evident: two diabetic children in the apparently healthy family. By comparing the condition of the treated and untreated cases, we realize the benefit from proper treatment, although we are seldom able to cure the diabetes. He thinks a cure has been realized in one of his cases; the older sister died in coma at 6, but in the younger sister, the glycosuria up to 30 gm. at the age of 3 yielded to treatment, and the child seems to have entirely recovered. The sugar content of the blood will differentiate renal diabetes, and a change to a milk-vegetable diet will banish the glycosuria when it is due merely to liver derangement. Alimentary glycemia may be useful in differentiation. Treatment of diabetes in children does not differ from that in adults, but it is harder to apply. He explains that pathologic acidosis differs materially from the acidosis from fasting. Too much fat and albumin, too much meat, are liable to entail coma. Protein is more dangerous than fat, and meat should be dropped. In one girl of 5 after trial of cereals, milk and vegetables for over a year, she thrives best on a legume diet. Milk combats acidosis but it increases the glycosuria, as also rice and potato. Green vegetables (from 500 to 1,200 gm. a day) supply minerals and alkali. He gives this diet for one or several weeks at a time and the children bear it well provided there is variety in the green vegetables. Flatulence and sometimes diarrhea are the drawbacks. On twenty days of this strict vegetable diet the glycosuria and acidosis subsided in one girl of 15 who had been showing symptoms for a month of grave diabetes, and there has been no recurrence during the year since. One girl of 3½ developed grave diabetes which grew worse on a diet of meat, fat and starchy foods. There was glycosuria of 120 gm. and 9 gm. of acetone bodies. In ten days of restriction to green vegetables, there was no further glycosuria and only traces of acetone. The diet was then gradually amplified but in two weeks glycosuria and acidosis reappeared, with somnolency, and again the symptoms subsided under a strict green vegetable diet, and the weight increased. Hygiene is very important; the child should live a quiet life under the constant surveillance of its parents, avoiding fatigue, chilling and infections.

Obesity in Children.—Lereboullet has noticed that the obesity for which endocrine glands can be incriminated is usually a partial, regional, not a diffuse, uniform obesity. With the latter, dieting and physiotherapy are the main reliance, but with endocrine obesity the gland or glands involved must be investigated, and the possibility of surgical treatment and radiotherapy considered, tentative treatment for syphilis applied, and organotherapy. In his experience, pituitary or suprarenal extract seemed to increase the efficacy of thyroid treatment.

May 13, 1922, **12**, No. 19

*Visceral Nitritoid Crises. H. Gougerot.—p. 393.
Treatment of Dyspepsia with Emaciation. F. Moutier.—p. 397.
Intratracheal Injections. J. Forestier and L. Leroux.—p. 403.

Visceral Nitritoid Crises.—Gougerot reports some cases in which neo-arsphenamin treatment caused a nitritoid crisis in the uterus, inducing abortion. In others the symptoms developed in the joints, suggesting acute articular rheumatism; or in the kidneys, inducing hematuria; or in the spinal roots, inducing intense pains and transient paraplegia. These mishaps all occurred with injection of the drug by the vein, and he now prefers the subcutaneous or intramuscular route for all pregnant women and for the frail and intolerant.

Presse Médicale, Paris

April 29, 1922, **30**, No. 34

*Phlegmon Back of Esophagus. J. Guisez.—p. 365.
*Leukocytes Under Epinephrin in Myelosis. J. Goia.—p. 366.
Present Status of Hemochromatosis. J. Reuillard.—p. 369.

Phlegmon Back of Esophagus.—In Guisez' three cases of this kind, in children from 13 months to 3 years old, progressive dyspnea with attacks of suffocation and hoarseness were the first symptoms, soon followed by dysphagia. Tracheotomy was required and the posterior trachea wall was found bulging inward instead of the anticipated foreign body. All recovered after the retro-esophageal pus pocket was incised through the esophagus. In adults the trachea being more resistant, dysphagia is the only symptom, the esophagus being squeezed more or less flat at all ages.

Action of Epinephrin on the Leukocytes.—First a phase of pronounced lymphocytosis, and then a relative polynucleosis follow the injection of epinephrin in the normal. In leukemia and other forms of myelosis the reaction differs characteristically, and allows diifferentiation of aleukemic lymphadenosis, etc.

Revue de Chirurgie, Paris

1922, **41**, No. 2

*Results of Treatment of Cleft Palate. V. Veau and Ruppe.—p. 81.
*Vomica with Amebic Abscess in Liver. G. Miginiac.—p. 100.
Astragalectomy. E. Destot.—p. 131.
*Wounds of the Knee. R. Simon and E. Stulz.—p. 134.

Cleft Palate.—Veau states that of the 89 operative cases treated by the classic procedures, the immediate result was good in 48 per cent., and in 74 per cent. after supplementary operations. Spontaneous improvement in speech followed in 25 per cent. and in 15 per cent. after systematic vocal training; in 60 per cent. no training was undertaken and there was no improvement in the functional results. The stiffness and shortness of the soft palate explained the failures, the raw surface inviting infection, and the cicatricial shriveling. No raw surface should ever be left, and the muscle fibers should not be cut, if possible to avoid this.

Vomica with Amebic Abscess.—Miginiac compares two personally observed cases with forty-nine he has found recorded since 1895. The vomica is almost always a grave complication, compelling an emergency operation and drainage of the abscess as if the vomica had not occurred. Emetin is a valuable aid and in exceptional cases can be depended on alone, if the abscess has been completely evacuated by the vomica.

Injury of the Knee.—Five cases are described in boys or men, the knee injured by being dragged by a vehicle in the street or by an ax wound. The operation followed within an hour or two. The joint was opened and the crushed tissues removed, the parts sutured, and then the joint was sutured again at once, and it healed in all with perfect function. Progressive mobilization was cautiously applied.

Riforma Medica, Naples

April 3, 1922, **38**, No. 14

*Microscopy of Bacilli in Sputum. N. Pane.—p. 313.
*Coagulation of Citrated Blood. G. Leone.—p. 313.
*Test for Bilirubinemia. A. de Martini.—p. 314.
*Roentgenotherapy in Typhoid. A. Pais.—p. 317.
Megacolon. V. Pauchet.—p. 318.
Epidemic of Grain Itch. E. de Longis.—p. 320.

Bacteriologic Examination of Sputum.—Pane remarks that the formaldehyd method of homogenization of sputum is very apt to dissolve the younger tubercle bacilli in the sputum, and modify the staining properties of some of the others. These drawbacks are particularly grave in incipient cases in which negative findings may waste precious time. He avoids these misleading findings by adding to the sputum four times its volume of physiologic saline and incubating at 37 C. for twenty-four hours. The proteolytic enzymes formed by the accessory micro-organisms during this period liquefy the mucus and cells in the sputum, and then centrifuging and staining show up the tubercle bacilli well.

Coagulation of Citrated Blood.—Leone poured a 30 per cent. solution of sodium citrate into the dog stomach but no influence even from 1 to 2 gm. per kilogram on the coagulating time of the blood could be detected afterward. Injecting a 25 per cent. solution subcutaneously, however, retarded the coagulating time to twice its former length in an hour and a half, and this effect was apparent for twenty-four hours. By the vein, in an amount equal to 1 gm. per kilogram, fractioned, with brief intervals, the blood became incoagulable almost at once, and this effect lasted for several hours.

Bilirubinemia.—De Martini calls attention to the delicacy and reliability of pure acetic acid as a reagent for bilirubin in the blood. The color reaction is exceptionally prompt and distinct, without precipitation of albumin, and he lauds this technic as superior to all others yet tested. He applied it in jaundice of various origins, comparing the findings with those of Hijman van den Bergh's modification of the diazo reaction, and using pure acetic acid or a 50 per cent. dilution. When there is insufficiency of the liver, more bilirubin passes into the blood, and the reaction occurs more promptly than when the proportion is less. He noted that the bilirubinemia and the bilirubinuria became more and more intense as the symptoms became more pronounced, the edema, dyspnea, albuminuria, alimentary levulosuria and jaundice.

Roentgen-Ray Treatment of Typhoid.—Pais applies the roentgen rays to the blood-producing organs in a merely stimulating dose, his assumption being that this stimulates the defensive forces, and is thus a potent aid in combating any acute infection. His experience in typhoid and malaria, he says, has abundantly confirmed this assumption. The dose was less than the smallest used in ordinary radiotherapy, and he exposed the spleen and other abdominal organs in five cases of typhoid. The organism responds to the exposures differently according to the stage of the disease and the hour of the day. The effect is unfavorable when the temperature is climbing, but progressive attenuation of the symptoms and immediate euphoria follow exposure of the spleen as the temperature is declining.

Medizinische Klinik, Berlin

April 30, 1922, **18**, No. 18

*The Gout Question. T. Brugsch.—p. 553.
*Pregnancy in Amenorrhea. R. Hofstätter.—p. 556.
*Gastric Sarcoma. H. Finsterer.—p. 561.
Spontaneous Pneumoperitoneum With Gastric Ulcer. Dahm.—p. 562.
Case of Leukemic Chloromyelosis. R. Höppli.—p. 563.
Hemangioma on Arm and Penis. F. Kroll.—p. 564.
Source of Error in Wassermann Test. K. Meyer.—p. 566.
*Factors in Arsphenamin Mishaps. F. Jacobsohn and E. Sklarz.—p. 567.
Pyelocystitis. K. Blühdorn.—p. 569.
Practical Questions in Obstetrics. E. Runge.—p. 570. Cont'n.
Present Status of Tartar Emetic as a Specific. Mayer.—p. 572. Conc'n.

The Gout Question.—Brugsch explains that the colorimetric method for determining the uric acid content of the blood has three sources of error. Hence the work that has been done with the Folin-Wu method has given misleading findings. The characteristic of gout is a relatively high uric acid content of the blood with a relatively low uric acid content of the urine. The experiences of the war have confirmed the advantage of restricting purins in the diet of the gouty. We have learned further that the purin metabolism is a neurologic-metabolic process, and that irritation of a certain center in the medulla oblongata—directly or by drugs—influences endogenous uric acid excretion. This *veizharnsäure* affords a new standpoint for study of gout: the stimulation of uric acid production and excretion by various foods and drugs in health and in gout. Uricolysis can be left entirely out of the question now.

Pregnancy During Amenorrhea.—Hofstätter discusses eleven cases of this kind. These women had been pregnant before, and this amenorrhea pregnancy was seldom carried to term.

Gastric Sarcoma After Resection of Stomach.—A large duodenal ulcer was found inoperable in the man of 51, and consequently only the stomach was resected (15:25 cm.). The man felt entirely well for nearly two years, when the pylorus end of the stomach was found the seat of a large sarcoma. The duodenal tumor had healed. The sarcoma was resected, with the adherent colon, but the man succumbed to metastasis four months later. Only about 200 cases of gastric sarcoma have been published, with radical operation in 60. Finsterer has had 2 operative cases himself; one man of 20 is still in good health nine years after the operation.

Ion Balance During Arsphenamin Treatment.—The research on rabbits reported seems to suggest that calcium in large doses increases the tolerance for arsenic while minute doses augment the toxicity.

Zeitschrift für Tuberkulose, Berlin

April, 1922, **36**, No. 2

*Tuberculosis of Male Genital Organs. P. J. Schultz.—p. 81.
*Ossification of First Costal Cartilage. F. Salomon.—p. 99.
*Artificial Pneumothorax. E. Schill et al.—p. 104.
*Experimental Chronic Tuberculosis in Rabbits. R. Arima.—p. 114.
Moro's "Diagnostic Tuberculin." E. Wever.—p. 117.

Tuberculosis of Male Genital Organs.—Schultz devotes 11 pages to the tabulated details of 125 cases. They demonstrate the rarity of primary tuberculosis of the testicle; there was no evidence of "testifugal" infection in more than a seventh of the cases. In practically all the others the infection proceeded from the prostate. These 125 cadavers were encountered among 14,086 necropsies, and there was always some other tuberculous focus or foci, recent or healed. The age peak was in the thirties, but 12.8 per cent. were between 60 and 70. The prostate was involved in 83.2 per cent., the vesicle in 64.4, and the epididymis in 52.8 per cent. In 28 per cent. the prostate was the only genital organ affected, and in 18.4 per cent. it was the only organ affected in the entire urogenital system. In 3 cases this was true of the seminal vesicles on one side. In 2 cases of miliary tuberculosis the prostate and the kidneys were the only urogenital organs involved.

Ossification of Costal Cartilage.—Salomon has been studying the frequency and the clinical import of ossification of the first costal cartilage from the standpoint of pulmonary tuberculosis, and especially the significance of the formation of a joint in the ossified cartilage. The cartilage was ossified in 26.5 per cent. of 1018 soldiers; in 16 per cent. of 1028 men and 3.4 per cent. of 680 women—all tuberculous. But no connection with the course of the lung process could be traced.

Technic for Artificial Pneumothorax.—Schill and his co-workers compared the physical and roentgen findings in regard to the conditions favoring artificial pneumothorax with the necropsy findings not long after in thirty-three tuberculous patients. The combination of electric, physical and roentgen investigation is much more instructive than the latter alone, supplemented by the extent of expansion of the lung, and the movability of the pleura. In some cases flat adhesions broke at a touch, and bands stretched allowing an effectual pneumothorax. This was exemplified in one case in which spontaneous pneumothorax developed the day before the patient died.

Experimental Chronic Tuberculosis in Rabbits.—Arima relates that he succeeded in inducing chronic tuberculosis by inoculating the parenchyma of the testicle with human tubercle bacilli. The intensity of the infection was proportional to the amount of material injected, and the disease subsided and the lesions healed in some. He does not know

of any instance on record of the healing of tuberculosis of the human type in a guinea-pig.

Zentralblatt für Chirurgie, Leipzig

Feb. 11, 1922, 49, No. 6

Postoperative Tetany and Anesthesia Accidents. Harttung.—p. 186.
Invagination After Gastro-Enterostomy. L. Arnsperger.—p. 190.
*Potassium Iodid as Contrast Medium. H. Lehmann.—p. 193.
*Technic of Late Two-Stage Prostatectomy. A. Wagner.—p. 194.

Potassium Iodid as a Contrast Medium.—Rubritius' success with a 10 per cent. solution of potassium iodid in roentgenography of bladder, uterus and renal pelvis induced Lehmann to apply the same to diagnose fistulas, abscesses and empyema cavities. The skin around the fistula is anesthetized with procain, a tobacco-bag suture is thrown about the fistular opening, a blunt cannula is passed into the fistula as far as it will readily go and as much potassium iodid is injected into the fistula as is possible without causing pain. The cannula is then removed and the suture is drawn taut. In a cold abscess the pus is drawn off, and a corresponding quantity of the solution is injected into the cavity and is retained by closing the puncture. The roentgen shadows are very intense. No unpleasant symptoms were observable. One advantage over pastes was that the fluid readily entered the smallest ramifying passages leading from the cold abscesses to the caries foci. There is no danger from poisoning, as with bismuth, and the fluid is much more easily removed afterward than bismuth.

Technic for Two-Stage Prostatectomy.—Wagner has found the mortality from prostatectomy materially diminished since the introduction of the two-stage operation. In all cases of prostatitis in which the single operation appears too dangerous, epicystostomy is performed to give conservative relief. As soon as the opportune time arrives for the operation, the prostate is removed transvesically. Patients often feel so much better after the bladder fistula that they put off the second operation—sometimes for months or even years. The technic of the second operation may become more complicated through long delay; the bladder shrinks and the peritoneum becomes adherent and it may tear at several points. Therefore, of late, when the second stage had been delayed, Wagner divided the peritoneum above the fistula and sutured it to the bladder. In this manner more space is secured if the bladder is small, and the fistula can be easily opened up further. This extraperitoneal exposure of the bladder much facilitates the operation; it does not complicate matters in the slightest, and shortens the length of the operation in many cases.

Zentralblatt für Gynäkologie, Leipzig

Feb. 18, 1922, 46, No. 7

Clinical and Pathologic Aspects of Adenomyosis. Frankl.—p. 241.
So-Called Hypnotic Twilight Sleep. Schultze-Rhonhof.—p. 247.
Hypnosis in Relation to Postoperative Deficit Symptoms. Wulff.—p. 258.
Technic of Roentgen Irradiation of Large Areas. W. Uter.—p. 259.
Diagnostic and Therapeutic Value of Pneumoperitoneum in Postoperative Adhesions after Laparotomy. Feldmann.—p. 262.
Subperitoneal Dermoid Impeding Childbirth. Kampschulte.—p. 266.
Primary and Late Results of Surgically Treated Chronic Tumors of Adnexa. A. Probstner.—p. 267.

Acta Medica Scandinavica, Stockholm

April 4, 1922, 56, No. 3

*Wassermann Reaction. T. E. Hess Thaysen.—p. 195.
Sudden Death from Embolus in Mitral Valve. A. Barkman.—p. 225.
Pharmacologic Tests of Narcotic Proprietaries. J. Grönberg.—p. 230.
*Clinical Capillaroscopy. K. Secher.—p. 295.

Wassermann Reaction.—Active Syphilis.—Thaysen affirms that a lesion that is not causing symptoms and probably never will induce symptoms should not be called active, whether the Wassermann reaction is positive or not. The syphilitic lesions found in the viscera at necropsy probably developed during the spirochetemia of the secondary stage. In a typical group of 57 cases, for instance, in which the positive Wassermann reaction is the only sign of syphilis, assuming that they had acquired infection at about the age of 25, the interval since has been from twenty-five to fifty years in 28 of the 57, and all of the 57 denied any knowledge of the original syphilitic infection; in 22 others the interval has been from ten to twenty years. Thaysen assumes that if they have gone twenty-five years without symptoms, the majority will go on to the end without symptoms, notwithstanding their positive Wassermann reaction. The visceral lesions found in such cases should be regarded like the latent fibrous tubercle in the lung, etc. (The article is in English.)

Capillaroscopy.—Secher's conclusions from research on 100 patients with kidney or heart disease or diabetes, and 30 controls, confirm the assumption of independent functioning of the capillary system. (In German.)

Norsk Magazin for Lægevidenskaben, Christiania

May, 1922, 83, No. 5

*Results of Food Scarcity. C. Flügge.—p. 321.
Indirect Transfusion of Blood. O. Borchgrevink.—p. 342.
*Uncontrollable Vomiting of Infants. C. Johannessen.—p. 347.
Myomectomy in Pregnant Uterus. A. Brekke.—p. 358.
*Research on Asthma. A. de Besche.—p. 361.
Partial Colectomy; Ten Cases. N. Paus.—p. 389.
*Operative Treatment of Nephritis. N. Paus.—p. 393.
Impalement and Stab Wounds. N. Paus.—p. 395.
Nail Extension of Fractured Femur. N. Paus.—p. 397.

Lessons from Food Scarcity.—Flügge reviews the scientific and practical points learned from the food scarcity of the last seven years in Germany. One lesson is the necessity of stimulating home production in times of scarcity by encouraging the farmers to organize for control and distribution, with prizes and no penalties. The fundamentals, bread, potatoes and milk, should be in the hands of a food administration service and be rationed. The rationing should be by age. There should be no official restrictions on other articles of food, but supplementary rations should be allowed proportional to the kind of work being done, the size, disease, etc. The supplementary ration should be specified by the physician; for example, a tall, energetic man doing strenuous work requires at least three times as much food as a small, phlegmatic adult in repose. It is enough for practical rationing purposes to determine the Rohrer index of nutrition and measure the thickness of the adipose tissue in a fold taken up in the abdominal wall close to the umbilicus. The amount of fat in the chest wall, whether ribs are visible or not, the light falling from above, and the tint of the mucous membranes are also instructive.

Habitual Vomiting of Infants.—In the course of this study of uncontrollable vomiting, Johannessen remarks that the roentgen rays have shown that the stomach contracts better when the food is less fluid. They have thus given a scientific basis to the empiric experience that infants who vomit all fluid food may be able to retain porridge. His experience confirmed this in six cases. With spasm of the pylorus, if papaverin does not relieve the spasm promptly, he urges pylorotomy at once. In his own two cases the infants had lost a third of their weight, and only one was saved. The air bubble was very large in all these vomiting infants, and this kept up a vicious circle.

Asthma.—De Besche tabulates the responses in 35 cases of essential asthma to various proteins, pollens, etc. In the 23 horse asthma cases, all responded to the de Besche eye test (touching the eye with the finger drawn over the hair of the horse or other animal, getting a little sweat on the finger); in 7 the Walker test, and in 13 the serum test was negative or dubious. One boy of 7 had asthma after eating egg or apple while his sister developed after the same not asthma but urticaria.

Surgical Nephritis.—Paus removed a kidney in 1909 on account of local pain and hematuria—no other symptoms—and the patient is still in the best of health. He recently encountered a case of hematuria with tenderness of the kidney but no pain. The diagnosis was hemorrhagic nephritis, although the urine was normal except for the hematuria and albuminuria. The kidney was cyanotic but otherwise normal, and all symptoms subsided after loosening up the capsule and cutting down into the kidney to relieve the pressure.

JOURNALS ABSTRACTED IN THE CURRENT MEDICAL LITERATURE DEPARTMENT, JANUARY-JUNE, 1922

The following journals have been abstracted in the Current Literature Department of THE JOURNAL during the past six months. Any of the foreign journals, except those starred, will be lent by THE JOURNAL to subscribers in the United States and to Fellows of the American Medical Association for a period not exceeding three days. Only one journal may be borrowed at a time. Requests for periodicals should be addressed to the Library of the American Medical Association and six cents in stamps should be enclosed. This covers the average expense of mailing a journal. Domestic journals can be obtained by sending the approximate amount direct to the respective publishers. Thus most of the journals indexed are accessible to the general practitioner, no matter where located.

Acta Chirurgica Scandinavica. Irregular. 20 kroner. Stockholm.
Acta Medica Scandinavica. Irregular. 20 kroner. Stockholm.
*Acta Pediatrica. Irregular. $6 per volume. Uppsala.
Acta Scholae medicinalis universitatis imperialis in Kioto. Irregular. 3.30 yen. Kioto.
American Journal of Anatomy. Bi-m. $7.50. 36th St. and Woodland Ave., Philadelphia.
American Journal of Diseases of Children. M. $4. American Medical Association, 535 N. Dearborn St., Chicago.
American Journal of Hygiene. Bi-m. $6. 310-312 Monument St., Baltimore.
American Journal of the Medical Sciences. M. $6. Lea & Febiger, 706 Sansom St., Philadelphia.
American Journal of Obstetrics and Gynecology. M. $6. C. V. Mosby Co., St. Louis.
American Journal of Ophthalmology. M. $10. 7 W. Madison St., Chicago.
American Journal of Physiology. M. $5. 1222 St. Paul St., Baltimore.
American Journal of Psychiatry. Q. $5. Johns Hopkins Press, Baltimore.
American Journal of Public Health. M. $5. 370 Seventh Ave., New York.
American Journal of Roentgenology. M. $6. Paul B. Hoeber, 67 E. 59th St., New York.
American Journal of Syphilis. Q. $7. C. V. Mosby Co., St. Louis.
American Journal of Tropical Medicine. Bi-m. $5 per volume. Williams & Wilkins Co., Baltimore.
American Review of Tuberculosis. M. $5. Williams & Wilkins Co., Baltimore.
Anales de la Facultad de Medicina, Montevideo. M. 6 pesos. Montevideo.
Anales de la Facultad de Medicina, Universidad de Lima. Bi-m. 6 soles. Lima, Peru.
Annales des Maladies Vénériennes. M. 52 francs. Paris.
Annales de médecine. M. 55 francs. Paris.
Annali d'igiene. M. 60 lire. Rome.
Annals of Medical History. Q. $8. Paul B. Hoeber, 67 E. 59th St., New York.
Annals of Otology, Rhinology and Laryngology. Q. $6. Times Bldg., St. Louis.
Annals of Surgery. M. $7.50. J. B. Lippincott Co., E. Washington Square, Philadelphia.
Annals of Tropical Medicine and Parasitology. Irregular. £1 2s. 6d. Liverpool.
Arbeiten aus dem Anatomischen Institut der Kaiserlich-Japanischen Universität zu Sendai. Irregular. Price varies. Tokyo.
*Archiv für Gynaekologie. Irregular. Price varies. Berlin.
Archiv für Kinderheilkunde. Irregular. 80 marks. Stuttgart.
*Archiv für klinische Chirurgie. Irregular. Price varies. Berlin.
Archiv für Verdauungs-Krankheiten. Irregular. 135 marks. Berlin.
Archives of Dermatology and Syphilology. M. $6. American Medical Association, 535 N. Dearborn St., Chicago.
Archives Franco-Belges de Chirurgie. M. 55 francs. Brussels.
Archives of Internal Medicine. M. $5. American Medical Association, 535 N. Dearborn St., Chicago.
Archives des maladies de l'appareil digestif et de la nutrition. Bi-m. 30 francs. Paris.
Archives des maladies du cœur, des vaisseaux et du sang. M. 36 francs. Paris.
Archives de médecine des enfants. M. 40 francs. Paris.
Archives de médecine et de pharmacie militaires. M. Paris.
Archives médicales belges. M. 30 francs. Liége.
Archives of Neurology and Psychiatry. M. $6. American Medical Association, 535 N. Dearborn St., Chicago.
Archives of Occupational Therapy. Bi-m. $5. Williams & Wilkins Co., Baltimore.
Archives of Ophthalmology. Bi-m. $6. G. P. Putnam's Sons, 2 W. 45th St., New York.
Archives of Radiology and Electrotherapy. M. £2, 2 shillings. Rebman Co., 141-145 W. 36th St., New York.
Archives of Surgery. Bi-m. $6. American Medical Association, 535 N. Dearborn St., Chicago.
Archivio italiano di chirurgia. Irregular. 90 francs. Bologna.
Archivio per le Scienze Mediche. Bi-m. 36 francs. Torino.
Archivos de Cardiologia y Hematologia. Bi-m. 24 pesetas. Madrid.
Archivos Españoles de Pediatria. M. 25 pesetas. Madrid.
Archivos Latino-Americanos de Pediatria. M. $5. Buenos Aires.
*Beiträge zur klinischen Chirurgie. Irregular. Price varies. Tübingen.
Boston Medical and Surgical Journal. W. $6. 126 Massachusetts Ave., Boston.
Brain. A Journal of Neurology. Irregular. 24 shillings. London.
Brazil-Medico. W. 25 milreis. Rio de Janeiro.
Bristol Medico-Chirurgical Journal. Irregular. 3 shillings per issue.
British Journal of Children's Diseases. Q. 25 shillings. London.
British Journal of Experimental Pathology. Bi-m. £2. London.
British Journal of Psychology. Irregular. 25 shillings. London.
British Journal of Surgery. Q. $10. William Wood & Company, 51 Fifth Ave., New York.
British Journal of Tuberculosis. Q. $2.50. G. E. Stechert & Co., 151 W. 25th St., New York.
British Medical Journal. W. 1 shilling 3 d. per issue. London.
Bulletin de l'Académie de médecine. W. 40 francs. Paris.
Bulletin médical. Semi-w. 20 francs. Paris.
Bulletin of the Johns Hopkins Hospital. M. $4. Baltimore.
Bulletin of the Lying-In Hospital, New York. Irregular. $1. Bulletin of Lying-In Hospital Press, New York.
Bulletin of the Medical and Chirurgical Faculty of Maryland. M. (except June, July, August and September) 25 cents. 1211 Cathedral St., Baltimore.
Bulletin of the Naval Medical Association of Japan. Irregular. Tokio.
Bulletin of the Porto Rico Medical Association. Bi-m. San Juan, Porto Rico.
Bulletins et mémoires de la Société médicale des Hôpitaux de Paris. W. 65 francs. Paris.
Calcutta Medical Journal. M. 10 shillings. Calcutta.
California State Journal of Medicine. M. $4. Butler Bldg., San Francisco.
Canadian Journal of Mental Hygiene. Q. $2. 207 St. Catherine St., West, Montreal.
Canadian Medical Association Journal. M. $6. 836 University St., Montreal.
*Casopis lekaruv ceskych. W. 170 k. Prague.
China Medical Journal. Bi-m. $5. Shanghai.
Chirurgia degli organi di movimento. Irregular. 55 francs. Bologna.
Colorado Medicine. M. $2. Metropolitan Bldg., Denver.
Crónica Médica. M. 15 francs. Lima, Peru.
Delaware State Medical Journal. Q. $1. 309 Shipley St., Wilmington.
Deutsche medizinische Wochenschrift. W. $6. Leipzig.
Deutsche Zeitschrift für Chirurgie. Irregular. Price varies. Leipzig.
Deutsches Archiv für klinische Medizin. Irregular. Price varies. Leipzig.
Dublin Journal of Medical Science. M. £1.5s.
Edinburgh Medical Journal. M. 40 shillings.
Encéphale. M. 70 francs. Paris.
Endocrinology: Bulletin of the Association for the Study of Internal Secretions. Bi-m. $6. 1100-1103 Title Insurance Bldg., Los Angeles.
Finska läkaresällskapets Handlingar. Bi-m. 60 Finnish marks. Helsingsfors.
Gaceta Médica de Caracas. Semi-m. 24 bolivares. Caracas, Venezuela.
Gann. Irregular. Tokio.
Glasgow Medical Journal. M. 30 shillings.
Gynécologie et Obstétrique. M. 65 francs. Paris.
Hospitalstidende. W. 30 kronen. Copenhagen.
Hygiea. Semi-m. 24 kroner. Stockholm.
Illinois Medical Journal. M. $3. 155 N. Ridgeland Ave., Oak Park.
Indian Journal of Medical Research. Q. 10s. Calcutta.
Indian Journal of Medicine. Q. Rs. 6. Calcutta.
Indian Medical Gazette. M. Rs. 14-8. Calcutta.
International Journal of Psycho-Analysis. Q. $6. London.
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SUBJECT INDEX

This is an index to all the reading matter in THE JOURNAL. In the Current Medical Literature Department only the articles which have been abstracted are indexed.

The letters used to explain in which department the matter indexed appears are as follows: "E," Editorial; "C," Correspondence; "T," Therapeutics; "Ml," Medicolegal; "P," Propaganda for Reform; "ME," Medical Economics; "ab," abstract; the star (*) indicates an "Original Article" in THE JOURNAL.

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SOCIETIES

A.—Association
Acad.—Academy
Am.—American
Coll.—College
Conf.—Conference
Cong.—Congress
Conv.—Convention
Dist.—District
Hosp.—Hospital
Internat.—International
M.—Medical or Medicine
Nat.—National
Pharm.—Pharmaceutical
Phys.—Physicians
Ry.—Railway
S.—Society
Surg.—Surgical or Surgeon, Surgery

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